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NURSING'S CONTRIBUTION

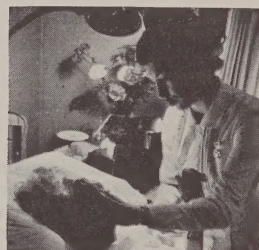
to a FAMOUS HOSPITAL



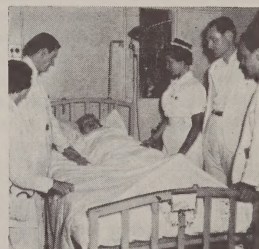
"The nursing department of the hospital adds its own special contributions to patient care, contributions often independently conceived and planned to meet the needs."—Ruth Sleeper



"No hospital worthy of the name can flourish without the influence of excellent women who are excellent nurses."—Edward D. Churchill



"Without nursing, no hospital administration nor hospital could exist."—Dean A. Clark



"Nowhere is the nurse's role as an interpreter and physician's ally so valuable and helpful as in clinical research."—Walter Bauer



"There has developed a natural alliance between the psychiatrists and the nurses, since both are oriented toward the patient as a person more than being concerned with the specific organs in a given illness."—Erich Lindemann

As the Massachusetts General Hospital celebrates its 150th Anniversary this year, the heads of its professional staffs consider the contributions of nursing to its history and development

... TO THE HOSPITAL'S PROGRESS

By Ruth Sleeper, Director of the
School of Nursing and Nursing Service

FOR the first 52 years after it was opened in 1811, the nursing care at the Massachusetts General Hospital in Boston was given by women who came untaught to dedicate their lives to the service of patients and hospital. The criterion for the selection of these women, described in a letter written in 1810 by Dr. James Jackson and Dr. John Collins Warren, was: "... that first requisite in sickness, a kind and skilfull nurse."

No exact number of the women employed to nurse the hospital's patients is recorded in the early reports of the trustees or resident physician. It would appear from the records that each ward in the Bulfinch Building had a "head nurse" and one other woman employee. Except for the ward tenders on the men's wards, these women and the wife of the resident physician were the nursing staff, the housekeepers, the "dietitians," and, within their limitations, the "social workers" for the new venture in the care of the sick.

The first major transition in nursing care came in 1873, when an independent training school for nurses was established by friends of the hospital and was permitted, though with many reservations, to send its pupils to the hospital wards to learn. Gradually, as these pupils proved their ability and devotion to their calling, the nursing care was shifted to other new "nurses" who, like their predecessors, also learned as they nursed. For these, however, a simple plan of training was provided, and some classes were taught by doctors and others, including the hospital's chef and pharmacist.

At first, the pupil nurses were restricted to two wards in the "Old Brick," a building in which patients with infectious conditions were cared for. By 1875, the value of the new type

of nurse was demonstrated, the patients on all wards were under their care, and the training school had assumed a dual function: to train the students and provide nursing service.

The contribution of the pupil nurses to both patient care and hospital services is further evident in the vote of the trustees in 1895 to accept full responsibility for the school, and by the following statements found in the *Annual Report* of the hospital in 1896:

The Training School for Nurses, which a year ago (January 1, 1896) was transferred by the managers and made a part of the Massachusetts General Hospital, has as in the past done admirable work. . . . The benefit of this work to the general public is very great, since through it there is developed a large body of skillful and highly trained nurses of excellent character.

By 1895, the pupil nurses were assisting in the operating room; in 1900, a graduate nurse was placed in charge of the surgical amphitheater; in 1901, a graduate head nurse was appointed for the outpatient department. The pupil nurses appeared in the newly opened diet kitchen, as nurse anesthetists, and as assistants in the x-ray department. As early as 1889, one of the graduates of the training school was appointed to the administrative staff of the hospital to look after patients' social needs.

The first statistics to show the volume of the nurses' contribution appear in a report dated just after the turn of the century. Then 22 employed graduate nurses and 85 pupils provided nursing service for a hospital of 282 beds. The numbers have risen steadily until today the figures show 367 student nurses and 47 teachers in the school of nursing, and a total of 447 graduate nurses and 291 auxiliary personnel in nursing service for a hospital

of 958 beds. Better to meet the needs of the patients and the hospital today, the responsibility for patient care has again been shifted. This time, to improve both quality and stability, this responsibility has been taken from the student nurses and assigned to the nursing service staff of graduate nurses and other personnel.

An estimate of the contribution made by nursing in this second century of the Massachusetts General Hospital's progress should be made in part by those whose special programs nursing influences. But it should also be recorded that the nursing department at the Massachusetts General today adds its own special contributions to patient care, contributions often independently conceived and planned to meet the needs. These include patient education, a major contribution to recovery or to a future life made more tolerable or more effective; patient referral, a contribution to continuing care after discharge; nursing education in the school of nursing, today a highly complex program for the preparation of professional nurses, sending out over 100 nurses each year, a part of whom will return to work in all areas of the hospital's program.

What would be the hospital's organization if nursing were suddenly removed? How would the medical program move forward without the contribution of nursing? Does nursing have a unique contribution to give to the professional care of patients and to the hospital? These questions are perhaps answered more objectively by other members of the MGH staff with whom we work day by day: the general director of the hospital, the chief of the general surgical services, the chief of the medical services, and the psychiatrist in chief.

... TO HOSPITAL ADMINISTRATION

By Dean A. Clark, M.D., General Director

TO EVALUATE the contribution of nursing to hospital administration in a short article is not easy, chiefly because that contribution is so great. Quite simply, without nursing no hospital administration (nor hospital) could exist.

In fact, nursing is the ultimate branch of hospital administration in all matters that directly affect patient care, excepting only the medical profession. It is through nursing that all of the hospital's services are *coordinated*, under the physician's orders, for the patient's benefit. This is nursing's largest administrative contribution.

But it is not the only one. Next, and at least equally important, is nursing's contribution to the *atmosphere* of the hospital. One of the administration's most puzzling tasks is to assure a hospital atmosphere that is warm and sympathetic for the patient and his family and, at the same time, to provide clinical nursing care that is scien-

tifically precise, prompt, and efficient so that the miracles of modern medical science can be wrought. Nothing determines—for good or ill—the hospital's atmosphere, for both purposes, as much as what nurses do and how they do it.

While making these two contributions, nursing automatically makes its third, *leadership*. Nursing, consciously or unconsciously, is the forerunner of all services given in the hospital, often including those of the doctor. Good nursing, by supplying intelligent coordination and a friendly yet effective atmosphere, makes it possible for the other services to make their own contributions (in themselves as important as those of nursing) to the best of their ability, in the same coordinated manner, and in a pleasant, yet precise, atmosphere. With inadequate nursing, no one else can function properly, however well intentioned and skillful he may be.

Nursing, of course, makes innumerable other contributions to administration. To cite but two: first, it is primarily nursing that assures *continuity* of the patient's care from admission through to discharge. Second, and somewhat more mundane, although crucial to administration, nurses have it largely in their hands to either promote *economy* (or encourage waste) in the hospital's operation. They do this partly through the efficiency of their own services and use of supplies but very largely, too, through the effect they necessarily have on the efficiency of others.

This quick review obviously cannot do justice to everything that nursing does to make a hospital operate satisfactorily (and what else does "administration" mean?) but it will perhaps suffice to show that nursing's contribution is very large indeed and it is one for which we all have the liveliest appreciation.

... TO THE CHARACTER OF THE HOSPITAL

By Edward D. Churchill, M.D., Chief of the General Surgical Services

IN 1862, Georgia Sturtevant sought and accepted a position as assistant nurse in the Massachusetts General Hospital at a salary of \$7.50 per month. Miss Sturtevant left a vivid description of the hospital at this period and of the arduous life of a nurse at that time. Instead of encountering the shocking sights and sounds she anticipated, the hospital wards of that day were a pleasant surprise.

True, there was suffering and there was pain to an extent unknown today, but a ward, as Miss Sturtevant described it, was a bright, airy room with dimity-curtained beds, each with a strip of colorful carpet spread beside it. Flowering plants flourished in the sunny windows and contributed to the cheerful and homelike appearance. Ward trays were set with solid silver and the hospital as a whole prided itself on its snowy white linen sheets and stand covers. Capacious fireplaces added cheer as well as comfort to the scene.

In the few private rooms the floors were covered with soft carpets, and lace draperies at the windows were crowned by damask valances known as lambrequins and surmounted by gilt cornices. No effort had been spared to

make the hospital as clean and attractive as the home "front parlor" which, in fact, was not infrequently converted into a sick room when need arose to care for illness in the home. Nurses were selected for their kindness and discretion and, like members of a family, submerged their own comforts and convenience in turning all efforts to the care of the sick.

The description of the hospital in the early years of its history is important to an understanding of its character and the influence it has had on the hundreds of nurses and doctors who have received their professional training within its walls. It contradicts the erroneous impression that this institution, because of its age, emerged from a more harshly motivated almshouse or pest house. The charter (1811) designated it as a *general* hospital in contrast to the only existing public refuge for the disabled—the old almshouse on Leverett Street. Admission to the almshouse was *only* for paupers and in the socioeconomic sense was a special institution. Its inmates were a mixture of the hopelessly diseased with social derelicts of all types. The new General Hospital was to be a socially constructive undertaking for the curable ills of

people of every socioeconomic level who, for one reason or another, could not receive the care they required in their homes.

Within this context, men and women of good will, trustees and lady visitors, doctors and nurses, clergy and social workers, carpenters and laundrywomen have worked together in common purpose ever since. To single out the contribution of any one group would distort the true image of MGH.

In the early days, the working day of the hospital nurse began at 5:00 A.M. and ended at 9:30 in the evening, with an occasional hour off if the work allowed it. The tasks of the day centered largely on systematic and meticulous housekeeping with the added responsibility of giving medicines as directed by the doctors. Skill in caring for the patients was acquired by "on the job" instruction given largely by the young doctors of the house staff, who in return probably learned more from the older experienced nurses than from the lectures that comprised the medical education of the day.

While the work was tedious and laborious and while the living conditions endured by these early nurses were rigorous and austere, many ear-

nest women who sought this employment as a means of livelihood found in nursing the sense of fulfillment that comes from being needed. They also found the stimulation and satisfaction that comes from participation in a group endeavor, and the constant challenge to cope with new situations and to deal with new personalities brought novelty to the tasks at hand.

Georgia Sturtevant began her work at the Massachusetts General Hospital a full half century after its foundation. Miss Rebecca Taylor began her career there only a few years after it was opened (1829) and remained in the position of head nurse for 34 years. Rebecca Taylor would be a dim and legendary figure today were it not for the warm note of appreciation in the writings of no other than Dr. James Jackson, the first head of the Department of Medicine. Dr. Jackson's profile, along with that of Dr. John C. Warren, is cast on the medal designed to commemorate the 150th anniversary of the hospital.

Miss Taylor was a small, well proportioned woman with her "contour derived entirely from the muscles" and "none of the rotundity caused by adipose matter near the surface." Her face was thin, the features well defined, her eyes blue, decidedly handsome and a "mouth full of expression." Everything about her radiated calmness and showed composure of mind. She seldom found fault with others and no one was ever heard to complain about Rebecca Taylor.

Dr. Jackson, among other anecdotes, relates:

A very excellent and intelligent woman, whom I had recommended for some years as a private, or family nurse, became very sick, and was brought to our hospital in a dreadful and helpless state. She was palsied, and had extensive bedsores at the time of her admission, so as to be very offensive. She retained her mental facul-

ties and was well qualified to criticize a nurse. "Oh, sir," she would exclaim to me, "you don't know—nobody knows—what an excellent nurse and what an excellent woman Becky Taylor is!"

"Nobody knows!" But, it also can be said that nobody knows the excellence of the wife of the New England farmer, who likewise worked from sunrise to darkness in the days of years spent in drudgery and toil; nobody knows the patience and diligence of some impetuous widow who strained her eyes over her work as a seamstress by a dim oil lamp long after the children had been given their supper and put to bed; nobody knows of the weary months of work and loneliness endured by wives and daughters of seafaring men of the bleak New England coast.

As the MGH looks back over its 150 years of experience it is a mistake to view with pity or indifference the many noble women who nursed the sick and cared for the suffering in the pretraining school days. Their lot was no worse, and in some respects perhaps better, than the lives of most women-folk of the period. Housewife or nurse, each was doing her share in the building of our society and the institutions in which we take pride today. These women were sustained by a conviction that their endeavor was important—a conviction the strength of which in the nurse far exceeded the techniques and skills by which it could be expressed. Through the glorious but equally toilsome effort of Florence Nightingale and her followers, these techniques and skills have been developed and systematized so that they may be passed along today to any bright girl who elects to acquire them. In sequence, hospital nursing has entered a phase in which techniques threaten to outrun the conviction that is so essential to their application.

It has been pointed out that it is impossible to deal separately with nurs-

ing or with surgery in the context of the MGH or to deal with the long interaction between the two. Whether they be Becky Taylors or Florence Nightingales, to understand the contribution of the host of excellent women who have worked as excellent nurses, to the hospital and to surgery itself, one must turn the clock back many decades by an intimate experience in the hospitals of the more remote parts of the world. A major and formidable barrier to the advance of surgery and medicine, as well as to medical education, in these lands is immediately apparent in the lack of competent and trained women in their hospitals. The breaking down of this barrier awaits the emergence of the Becky Taylors and the Georgia Sturtevants, and ultimately a Florence Nightingale. For us to drill their young women in the skills and technology of nursing is not enough and may, if this is all they learn, do harm.

In patriarchal societies womanly compassion for the sick and helpless must extend itself beyond the devotion to family or tribe which now marks its limits. The women of these developing lands must gain for themselves the independence and confidence that only education and contacts outside some mud-walled enclosure can nurture. Happily, these changes are slowly taking place in even the most underdeveloped areas, and the time is not far distant when all health professions that center in a hospital can move forward together to contribute to the making of the healthy citizenry so vital to staff and maintain a twentieth century community and state. But no hospital worthy of the name can flourish, nor can surgery advance within it, without the influence of excellent women and excellent women who are excellent nurses. Their all-pervading influence over 150 years has made MGH what it is today.

. . . TO THE MEDICAL PATIENT AND MEDICAL RESEARCH

By Walter Bauer, M.D., Chief of Medical Services

DURING the past ten years the nursing service at MGH has established and maintained a closer working relationship with the medical service. This has required increased communication and cooperation at all levels of the medical and nursing service staffs. To facilitate this, the office of the assistant director of nursing is now adjacent to that of the chief of the medical service. She attends the weekly meetings the chief of the medical service holds with the medical residents, and meets at regular intervals

with the members of the house staff and the nurses in charge of the medical wards. These meetings have led to better understanding of the problems that arise on the medical wards.

It is in this setting that the members of the ward team (physicians, nurses, medical and nursing students) become increasingly cognizant of their respective roles, present and future. In this brief statement, I wish to call attention to the increasing role of the nurse on the medical service in the care of patients and in medical research.

The medical nurse has become more proficient in recognizing the many symptoms of illness and in carrying out the ever increasing complex therapeutic procedures. She aids both the patient and the physician, attempting to interpret each to the other, thereby making the relationship more fruitful and pleasant. She is the link between the doctor and the patient. I believe she is very aware that "whether the link jaws or jangles, or whether it functions without friction, depends on what went into its forging." I trust that

many doctors today have like insight.

The nurse serves as the liaison between the patient and the doctor, clarifying his instructions, reinforcing his assurances, illuminating whatever may be obscure, administering and carrying out whatever may have been prescribed, whether medicinal or not. This is no easy task but one which she tries hard to discharge. She has become an increasingly skilled observer and interpreter of the patient's reactions, both physical and emotional, reporting not only the behavior and measurement of various bodily functions, but also his fears, anxieties, or abnormal behavior. In the real sense, she strives hard to supply the doctor with another pair of trained hands, another pair of discerning and discriminating eyes. This dual role of the doctor's ally and patient's supervisor, companion, or confidant is not an easy one, but when skillfully played, the re-

sults have been immensely gratifying to all concerned.

That considerable skill and tact are required to accomplish this, there can be no doubt, since the nurse has an obligation to both the patient and the doctor. In most instances, these loyalties are not in conflict, for the patient's welfare is the overriding concern. Occasionally, however, when a gulf appears between patient and doctor, for whatever reason, it is the skillful nurse who unobtrusively but effectively narrows or eliminates it. Problems of this sort do arise on a busy medical ward where several doctors may be engaged in the care of a single patient.

Nowhere is the nurse's role as an interpreter and physician's ally so valuable and helpful as in clinical research. Depending upon the nature of the investigation, there may be repetitious observations, meticulous collection of specimens, and, for the patients, the

ingestion of monotonous or unpalatable diets, sometimes for prolonged periods. The nurse indoctrinates the patient in the cause of research and his own contribution to it. The cooperation and enthusiasm of the patient will often depend on the nurse's encouragement and explanation and how well she communicates the nature and purpose of the study. Above all, she takes the lead in promoting his happiness during his stay on the ward.

It is more apparent today than ever before that whenever the physicians of the medical service deal with patients, little can be accomplished without the invaluable aid of the discerning and understanding nurse. This is due to the fact that our nurses have been prepared to act as the doctor's ally and colleague in the healing art and in helping patients toward a more positive approach to health. This augurs well for the future.

... TO PSYCHIATRY

By Erich Lindemann, M.D., Psychiatrist in Chief

THE psychiatric service of the Massachusetts General Hospital has just celebrated its twenty-fifth anniversary. This service was established by Dr. Stanley Cobb to satisfy three basic concerns: first, facilities were needed for the care of patients with the acute mental disturbances which may develop in the course of medical or surgical diseases; second, patients whose complaint and impairment were primarily due to psychogenic causes in the form of psychoneuroses or psychosomatic disorders needed resources for competent psychotherapy and a suitable environment for such therapy; third, the many issues of emotional conflict, lack of cooperation on the part of the patients, and the reactions to serious social strain in the family and the community which interfere with the patient's motivation for recovery had to be understood and handled wisely to strengthen the over-all program of medical care.

To serve these functions, a special ward was developed which required highly organized teamwork between the psychiatrists and the nursing staff to provide an optimal environment for patients with emotional difficulties. A good many of these patients are not bed patients in the narrow sense, but have to be active and occupied in a suitable manner throughout the day. Much understanding and emotional support is required on the part of the nurses, and many organizational problems arise on the ward as we try to integrate psychiatric nursing care, oc-

cupational therapy, and activity programs and to relate all of these to effective psychotherapy.

The nurse is a much valued observer of the subtleties of emotional adjustment and plays a key role in the support of the emotionally deprived and conflict-ridden persons during critical periods. Confusion and depression, suicidal tendencies, and suspicions have to be accepted, tolerated, and understood in a constructive manner in order to help the patient master a life crisis. It is this "psychodynamic" approach to the patient's problem that has necessitated such close teamwork of all the caretaking staff and has required a high level participation of the nurses in the therapeutic program. Their spontaneity and resourcefulness is often a key to the solution of behavioral emergencies. We have been most fortunate in being able to rely on the enthusiasm, dedication, and high level of competence of the nurses assigned to our service.

As both nurses and staff developed progressively more insight and skill in psychiatric therapy, it became possible to make use of this competence in the other services of the hospital. The psychiatric consultant has been able to count on understanding cooperation of the nurses in the solution of the psychological aspects of patient care. Indeed, there has developed a natural alliance between the psychiatrists operating as "medical anthropologists" and the nurses, since both are oriented toward the patient as a person and as

a social being more than being concerned with the specific organs involved in a given illness.

Nursing was quick to take advantage of the skills in "mental health consultation" which the psychiatric department developed in its new mental health service. Several discussion groups were organized among nurses, psychiatrists, and psychologists at various levels of the organization of nursing services. These conferences led to a remarkable exchange of insights and of techniques for solving psychological and interpersonal problems which affect not only the recovery of certain patients but also the happy and effective functioning of the caretaking personnel. The results of this type of cooperative endeavor were particularly useful when new forms of patient care were organized, such as the rehabilitation service. The problem of the motivation of patients and personnel and the development of new role functions of the different professional groups were central to this development, since the program includes educative measures as well as therapy.

In summary, both in the psychiatric care proper which goes on in our special psychiatric wards, and in the "infiltrating" components of psychiatric work in cooperation with other services, the participation of nurses has been crucial to the development of the type of general hospital psychiatry which is recognized as one of the contributions of MGH to the improvement of medical care.

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THE CONTRIBUTION OF WOMEN
to
THE MASSACHUSETTS GENERAL HOSPITAL

by

Edward D. Churchill, M.D.

John Homans Professor of Surgery, Harvard University
Chief of the General Surgical Services, Massachusetts
General Hospital

Written for "The Nursing Outlook", January 1961.

In 1862 Georgia Sturtevant sought and accepted a position as assistant nurse in the Massachusetts General Hospital at a salary of \$7.50 per month. Miss Sturtevant has left a vivid description of the Hospital at this period and of the arduous life of a nurse at that time. Instead of encountering the shocking sights and sounds she anticipated, the hospital wards of that day were a pleasant surprise. True, there was suffering and there was pain to an extent unknown today, but a ward, as Miss Sturtevant described it, was a bright, airy room with dimity-curtained beds, each with a strip of colorful carpet spread beside it. Flowering plants flourished in the sunny windows and contributed to the cheerful and homelike appearance. Ward trays were set with solid silver and the Hospital as a whole prided itself on its snowy white linen sheets and stand covers. Capacious fireplaces added cheer as well as comfort to the scene. In the few private rooms the floors were covered with soft carpets and lace draperies at the windows were crowned by damask valances known as lambrequins and surmounted by gilt cornices. No effort had been spared to make the Hospital as clean and attractive as the home "front parlor" which in fact, was not infrequently converted into a sick-room when need arose to care for illness in the home. Nurses were selected for their kindness and discretion and like members of a family submerged their own comforts and convenience in turning all efforts to the care of the sick.

The description of the Hospital in the early years of its history is important to an understanding of its character and the influence it has had on the hundreds of nurses and doctors who have received their professional training within its walls. It contradicts the erroneous impression that this institution because of its age, emerged from a more harshly motivated almshouse or pest-house. The charter (1811) designated it as a General Hospital in contrast to the only existing public refuge for the disabled - the old Almhouse on Leverett Street. Admission to

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In the early days the working day of the hospital nurse began at 5:00 a.m. and ended at 9:30 in the evening, with an occasional hour off if the work allowed it. The tasks of the day centered largely on systematic and meticulous housekeeping with the added responsibility of giving medicines as directed by the doctors. Skill in caring for the patients was acquired by "on the job" instruction given largely by the young doctors of the house staff, who in return probably learned more from the older experienced nurses than from the lectures that comprised the medical education of the day. While the work was tedious and laborious and while the living conditions endured by these early nurses were rigorous and austere, many earnest women who sought this employment as a means of livelihood found in nursing the sense of fulfillment that comes from being needed. They also found the stimulation and satisfaction that comes from participation in a group endeavor and the constant challenge to cope with new situations and to deal with new personalities brought novelty to the tasks at hand.

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nurse for thirty-four years, Rebecca Taylor would be a dim and legendary figure today were it not for the warm note of appreciation in the writings of no other than Dr. James Jackson, the first head of the Department of Medicine. Dr. Jackson's profile along with that of Dr. John C. Warren, is cast on the medal designed to commemorate the 150th anniversary of the Hospital.

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As the M.G.H. looks back over its 150 years of experience it is a mistake to view with pity or indifference the many noble women who nursed the sick and cared for the suffering in the pre-training school days. Their lot was no worse, and in some respects perhaps better, than the lives of most women-folk of the period. Housewife or nurse, each was doing her share in the building of our society and the institutions in which we take pride today. These women were sustained by a conviction that their endeavor was important - a conviction the strength of which in the nurse far exceeded the techniques and skills by which it could be expressed. Through the glorious but equally toilsome effort of Miss Florence Nightingale and her followers these techniques and skills have been developed and systematized so that they may be passed along today to any bright girl who elects to acquire them. In sequence, hospital nursing has entered a phase in which techniques threaten to outrun the conviction that is so essential to their application.

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NOW IS THE TIME

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Of course patients have been nursed in our hospitals for many decades, sometimes well, sometimes inadequately. How much of this success or lack of success was due to the basic education provided for nurses; how much was due to the lack of preparation of teachers and supervisors; how much was due to insufficient financing of the educational program; how much was due to poor hospital organization and staffing? History records incidents which indicate all of these factors were at one time or another involved.

There have been and in fact still really are no valid criteria to judge the degree to which patients' needs are met. If I were to look back forty years ago at the patients for whom I cared to make an evaluation, would I say their needs were met or their care was good? Of would I remember the boys always to be lame because of infections following compound fractures, or those patients who suffered for months and died with complications following

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Now is the time ---- The hackneyed phrase repeated over and over again by would-be typists "Now is the time for all good men to come to the aid of their party" might well be paraphrased to turn my title into a more pertinent sentence. Now is the time for those interested in nursing to come to the aid of their country - for surely this country's health services need some group to make a decision about nursing which will enable us all to stop unnecessary discussion on this issue of education and professional status, and to get down to the fundamental issue which is how are we to provide the kind of nursing care the people of this country need to have today or in the foreseen future. Now is the time --- to plan.

Of course patients have been nursed in our hospitals for many decades, sometimes well, sometimes inadequately. How much of this success or lack of success was due to the basic education provided for nurses; how much was due to the lack of preparation of teachers and supervisors; how much was due to insufficient financing of the educational program; how much was due to poor hospital organization and staffing? History records incidents which indicate all of these factors were at one time or another involved.

There have been and in fact still really are no valid criteria to judge the degree to which patients' needs are met. If I were to look back forty years ago at the patients for whom I cared to make an evaluation, would I say their needs were met or their care was good? Of would I remember the boys always to be lame because of infections following compound fractures, or those patients who suffered for months and died with complications following

pneumonia? Would I say their medical care in the 1920's was poor because infections could not be controlled, or would I say a whole new dimension had been added to medicine today with the discovery of the chemotherapeutics and antibiotics. Would I say my nursing care was poor because I spent so much time doing dressings, or would I say today a new dimension had been added to nursing? Today's patient is different. He may want some care such as his predecessors had, but he also wants today's advantages. Today's family is different. They want the patient returned for a short, well planned, convalescence at home, ready to regain every possible degree of health and usefulness. Today's doctor is different. He expects a co-worker whose nursing care will complement and supplement his medicine, with patient, with family, and with other medical co-workers. Today's hospital is different. Realization is coming that nurses will succeed best, that hospitals will be better administered if nurses are allowed to nurse.

To match this changing situation today's nurses must be different too. This difference cannot be only a matter of numbers. Logic tells us of course that there will be more patients in hospitals and at home. And the quantitative factor needs attention. But the added dimension to which I refer is qualitative. In it the nurse works as co-equal with doctor, carries out orders, but also possesses and uses the scientific knowledge necessary to plan with the doctor and take responsibility for cooperative action, but able also to act independently and to deal successfully with social and emotional problems.

Mrs. Mary Rockefeller, speaking at the National League for Nursing Convention in 1963, perhaps described this dimension best from the patient's point of view. "The doctors, the nurses, allied members of the health team, have all contributed to building up in the public mind a picture of 'the healing

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arts' -- a physician, a nurse, and now an entire health team whose intended purpose is to give the patient the feeling that they care, that they are involved in him as a human being, and that they are sharing his burdens and helping him until he can resume complete responsibility for himself.

"Contrast this with just one of the procedures today in a large modern hospital - the admission of a patient for an operation. I won't go into a full description, for you all know it anyway. Suffice it to say here that the patient finally emerges stripped of literally everything he owns, including his teeth, and clad in perhaps the most undignified garment ever devised by man. And more often than not he has had no preparation as a human being for this experience. His body has been prepared for surgery according to the safest most up-to-date scientific method, but what happens to the individual human being in the process and who cares?"

In my own thinking this added dimension is the ingredient in nursing which makes a kind of "people to people" program. Formerly and too often today people come to the hospital, they receive therapy, then go home as patients. The primary emphasis is on the cure of disease. The patient is cared for. The person does not express his needs or wants. As the very center of the therapeutic plan he is not accorded the respect which would permit him to share in the planning or implementation of his care. As a patient he becomes a kind of second class citizen. I want nursing care which will help to send him home again a person, having, doing, knowing all that will help him to retain his place in his family and in his community, in spite perhaps of a residual physical or even emotional handicap.

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could not differentiate those factors which made the same care comprehensive for one patient but in omprehensible to another. Nor did these nurses see that care of the whole patient was not a matter of attention to body, mind, and spirit, but rather a plan of care which sent the individual home a whole person and in so far as possible safeguarded the integrity or wholeness of his family as well.

Such care is not planned or given by the untaught or the trained-on-the-job. Kindness, common sense, understanding, gentle hands even when combined with an alert mind, do not add up to make a balanced equation in nursing. Technological changes come almost literally overnight in the health field, too rapidly to make education through experience alone sound or appropriate. Now, more than ever is the time for the right decision about nursing education. Here I shall sound as if I were playing the same old record. First, I believe all forms of nursing education in the health field should be supported because they serve the needs of people and not because any education will bring status or privilege to those who are fortunate to study in it. Because needs of people make demands of varying complexity and because methods used to meet these needs are derived from the dynamic sciences there should be broadly conceived educational programs to prepare nurses to work as scientists in the field. Second, because such nurses will seldom if ever give all the care necessary, and because it would be uneconomical to use such skills for complete patient care, other nurses will be needed. These may be less broadly prepared and should possess skill in technics. Since they will deal with people or people plus mechanical devices and technics, these nurses should also balance their technical skills with social skills which will help to maintain the integrity or the wholeness of patient and family as well as to help these nurses themselves to

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live and work effectively in their own nursing and social milieu. To maintain the educational system there must of course be teachers. To organize and bring an effective system of care there must be administrators. To keep nursing in step with change, in fact that nursing may appropriately assume leadership in initiating change, there must be nurses prepared for research.

Call these nurses what you will. I would designate the broadly prepared nurse as a nurse clinician. She would be prepared in the university where the necessary education is available. The less broadly prepared I would continue to call nurse. She is and will continue to be the public image of nurse. I would prepare her in the community or junior college and for the foreseeable future in the good hospital controlled school of nursing.

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You will note that I have omitted to mention the practical nurse. My omission was not intended to indicate that I would omit this area of nursing education or this practitioner. On the contrary, I would choose, if I had my way, to replace the trained on-the-job aide with the Licensed Practical Nurse. I would then have more assurance that the Licensed Practical Nurse had been

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adequately taught, that like the Registered Nurse she is under the jurisdiction of the Nurse Practice Act. Until staff education programs are more effectively planned and implemented, until hospitals see their responsibility more clearly to finance adequate programs; until nurses are prepared to plan and implement and continuously implement an adequate in-service program, the Licensed Practical Nurse in my opinion will give care with a higher safety quotient.

My concept of nursing education for this future is not really as status quo as it first sounds. I would expect the university school of nursing to grow even more different in its teaching, and to product graduates who stand out as educated women and as different nurses who have a different role, who know and carry out this role. As nurses knowledgeable in the social sciences, I would expect understanding of the current situation and how to work in it as well as to help to change it. I would expect more emphasis on difference in performance than on status.

I would expect the community college program to recognize the problems of its graduates who go upon graduation to hospitals other than those in which they have had experience, and I would hope these colleges would take steps to modify their programs accordingly.

I would expect in the foreseeable future both university and community colleges would recognize the value of a period of post graduation practice whether this be or not, as in medicine, dietetics, and teaching, an internship.

I would expect that those hospitals which operate schools for nurses would continue perceptibly to improve their teaching, that their graduates might be able technically and personally to meet the changing demands. I would expect also that these schools would see the impossibility of preparing a truly professional

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SPECIAL ARTICLE

NURSING EDUCATION IN EVOLUTION

RUTH SLEEPER, R.N.*

BOSTON

NURSING education, like other systems of education for the professions, has been shaped in its evolution by cultural and social change. Unlike most of the other systems, nursing education alone seems not to have moved from one distinct phase to the next, but to have retained the old patterns as each new phase emerged.

An examination of the plan for the education of nurses in 1964 will show at least three systems for the registered nurse, each quite distinct and each appearing as the result of changes in general education, in hospitals, in medicine or in community health programs. Each system, too, has its antagonists, and each its strong supporters.

The influence of the hospital in the training of the nurse was firmly established in 1860 when Florence Nightingale placed the School that was to bear her name under the direction of a matron who was also in charge of the hospital nursing. The School was independent but used the Hospital facilities. The matron was responsible both to the board of control for the School and to a separate board of control for the Hospital. For the matron Miss Nightingale planned a position of equality with the doctor, a position to be superior in authority for nursing to that of the existing hospital administration. She gave the matron, the nurse, both authority and responsibility to speak for the School. Hers was the decision.

Unfortunately, Miss Nightingale's system was never completely imported into the United States. The concept of trained nursing borrowed from the Nightingale School was introduced here before either a well laid plan or an informed leadership had been prepared. The independence of the School, the authority of the nurse and the educational plan itself were all too soon absorbed by the Hospital. When the first three training schools were opened "on the Nightingale plan" in 1873 there were 149 hospitals already in operation. By the turn of the century there were 4000 hospitals, of which 432 had training schools.¹ Obviously, the women selected to direct the nursing in these institutions had no nursing resources to call upon except as they created schools. There was no counterpart here of Florence Nightingale. No one in those early years possessed her knowledge or had her vision. No one then in nursing in the United States could command such authority. Neither doctor nor

hospital administrator saw the educational lacks or the evils of such rapid expansion.

So training schools grew with little regard for any objective beyond the immediacy of the patients' care and the influence of the doctors' demands for nurses in the hospital and the home. In fact, it has been said that if the goal for these early schools had been defined, it would not have been to train nurses but first to demonstrate that skilled nursing care was superior to unskilled. Whatever the objective, hospitals multiplied, training schools were opened, and a public, ignorant of the situation, sent its daughters to prepare for this new career in training schools, good and poor. Trained nursing, as established by Miss Nightingale, had now in the United States become hospital training for nursing. In 1909 there were over 1096 training schools. By 1927, when the number of hospitals had reached 7416,² 2155 of these institutions had established schools.

Meanwhile, the influence of the nurse in the United States began to be evident. Superintendents of training schools, alarmed at the unhealthy numerical growth without control of sound standards, or of authority to direct the situation, were aroused. In 1893, the American Society of Superintendents of Training Schools for Nurses of the United States and Canada was organized. This association was to give priority to the establishment and maintenance of a universal standard of training, to agitate this matter, to get the ear of training-school boards, to inspire confidence that proper standards must be achieved and to "hammer" always at the need.

And their hammers still resound. They strove to secure alumnae associations in the influential schools. They supported the organization of the Associated Alumnae of the United States and Canada. They worked with the Associated Alumnae, later in this country to become the American Nurses' Association, to obtain state registration to raise standards of education and practice. They supported plans for a national publication, the *American Journal of Nursing*. They participated in the planning of the Hospital Economics course at Teachers College, Columbia University, in 1899 to prepare administrators and teachers in nursing. Organized nursing now added its influence.

The growth of hospital schools was not checked immediately, but some hospital authorities and medical men, and some enlightened citizens, saw the conflict developing between the demands for pa-

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tient care placed upon the student nurse and her need for adequate instruction and time to learn. In 1909, through the influence of Dr. Richard Olding Beard, of the Medical School, and Dr. Louis Baldwin, superintendent of the University Hospital, a basic school of nursing was established at the University of Minnesota. This was a three-year program, and in many respects was similar to its hospital counterpart. But its relation to the University was assured, its philosophy was educationally sound, and its program far in advance of that in the schools conducted by hospitals. A second system for the education of the nurse had been introduced. Other colleges and universities became interested. In 1918 plans began for a study of nursing that culminated in 1923 in the Rockefeller Report on the "Study of Nursing and Nursing Education in the United States." Ten years and many meetings later the Association of Collegiate Schools of Nursing was organized "to develop nursing education on a professional and collegiate level, to promote and strengthen relationships between schools of nursing and institutions of higher education, and to promote study and experimentation in nursing service and nursing education."³ With the support and guidance of the Association of Collegiate Schools of Nursing, and later the National League for Nursing, into which the Association merged, collegiate nursing programs progressed from jointly conducted hospital and university programs into programs with full university status controlled and administered by the university. The second distinct and separate system of nursing education was now well established, combining the values of a liberal education with those of an education in nursing.

Other studies followed. *Nursing Schools Today and Tomorrow* in 1932 by the Committee on the Grading of Nursing Schools⁴ pointed out the low standards of education resulting when the schools were not educationally oriented. *Nursing for the Future*⁵ by Esther Lucile Brown in 1949 emphasized the need for a reorganization of nursing education to fit it into the educational pattern of the country and the need for collegiate preparation for the nurse who was to be adequate to the medical and health programs in the second half of the twentieth century. In 1950 *Nursing at the Mid-Century*,⁶ a report of the National Committee for the Improvement of Nursing Services, gave wide publicity to a classification of nursing schools and provided the impetus needed for a more effective accreditation and school-improvement program. The public had now become involved in the problem of nursing education, an influence that was to forward even more rapidly the development of nursing programs in universities and colleges, including the junior or community college.

In 1952 R. Louise McManus and Mildred Montag, in the Nursing Education Division of Teachers College, Columbia University, directed a research

project in Junior and Community College Education for Nursing.⁷ Seven junior colleges participated in the five-year project. Others developed nursing programs during the same period. This plan, like the four-year basic collegiate program, tapped the growing supply of young women, and men, interested in both further general education and nursing. This plan also offered opportunity for nursing to move into the stream of general education. It was college planned, directed and financed. Its students went into the hospital with college instructors to follow an educational plan focused only on the students' learning needs. Whatever nursing service resulted from their activities was to be an incidental by-product.

Junior-college applicants sought the new opportunity, many public and some private junior colleges willingly added nursing curriculums to their programs, and by 1957, the third system of nursing education, the second under frankly educational control, was underway.

Before the close of World War II it was evident that the supply of nurses would not keep pace with the growing demand from nursing services in hospitals, nursing homes, doctors' offices, industry or community health programs. The expanding hospital and medical programs and the nurses' assumption of functions heretofore carried by the doctor made urgent the need to increase the numbers of licensed practical nurses working in hospitals. To the existing independent schools and schools in hospitals for the training of the practical nurse were added postsecondary-school programs, frequently in high schools. Under the direction of the state vocational educational system, and with technical and financial assistance of the federal Government, these programs, twelve to fifteen months in length, increased from 150 in 1950 to 662 in 1960. Originally introduced to improve the care of the sick at home, the practical-nurse training now supplies an important segment of the nursing personnel in hospitals and nursing homes.

The need for teachers, supervisors and administrators in schools that admit over 49,000 student nurses and over 24,900 practical-nurse students is alarmingly urgent. When schools do not have teachers either applicants will be turned away or instruction of poor quality will be given. If hospitals lack adequate supervisors and administrators both patient care and student learning will suffer. If both nursing education and nursing service lack nurses prepared for research the quantitative growth of the profession as a whole and the quality of its contribution to the nation's health program will regress. In 1961 colleges and universities granted 1009 master's and 11 doctoral degrees in nursing, only a small proportion of the number needed, but tangible evidence that educational influences were at work to raise the level of the practice of nursing.

When the "Report of the Surgeon General's Con-

sultant Group on Nursing"⁸ was published in 1963 the seriousness of the situation became evident both to the nursing profession and to the public at large. There are today in this country 875 three-year hospital programs, 84 two-year programs in community or junior colleges and 176 four-year programs conducted by colleges and universities. These programs in 1961 admitted 37,700, 2100 and 8700 respectively — a total of 49,500 student nurses. Graduation figures for the same year show that of the 30,000 graduates, 84 per cent were from the three-year hospital-diploma programs, 3 per cent from the newly developed two-year associate-degree programs, and 13 per cent from the four-year baccalaureate-degree programs. Practical-nurse programs in the same year, with generous federal financial support, admitted 24,955 students. Out of every 1000 seventeen-year-old girls in the United States in 1960-61, 17 went into practical-nurse schools, and 34 to registered-nurse programs of two, three or four years.

Regionally, these admissions varied as educational trends and traditions vary. For example, in New England, where the community-college development is less rapid, publicly supported colleges fewer in number and the tradition of the hospital school long established, of every 1000 seventeen-year-old girls, 7.5 enrolled in the baccalaureate, 0.5 in the associate-degree, and 49.6 in the hospital school. In the Mountain region, 12.9 chose the baccalaureate degree, 2.9 the associate degree, and only 12.9 the hospital school.

Considering the growing need for nurses, the Surgeon General's Group has recommended an increase of 130,000 practicing registered nurses by 1970. This will bring the total to 680,000, a number far below the estimated need, but possibly within reach of accomplishment. This is not recommended to be just a broad increase, but a studied increase based on future need. The recommendation asks for a 445 per cent increase in the graduations from the two-year colleges (917 to 5000), a 58 per cent increase from the three-year hospital schools (25,311 to 40,000) and a 98 per cent increase from the baccalaureate programs (4039 to 8000).

Many factors entered into this decision. In the first place, the graduate with the baccalaureate degree has in her basic program prepared the educational foundation upon which specialization at the level of the master's degree can be built most soundly and expeditiously. She may move when professionally ready into advanced preparation for teaching, supervision or administration, or she may specialize in some area of nursing as maternal-child, mental-health and psychiatric nursing, or medical-surgical nursing. For graduates of two-year or three-year programs many educational lacks must be filled, and the baccalaureate degree earned, before the nurse is eligible for advanced study.

Secondly, the public popularity of the two-year

college opens significant avenues for recruitment, and its financing is often through tax support. The hospital school, greatly changed through a vigorous school-improvement program conducted by the National League for Nursing, will continue to provide the backbone of the nursing for direct patient care for many years to come. There are many problems to be faced by the hospital school, however, the outstanding one being financial support. The early training school was the nursing service. Long hours and little instruction combined to make the school a decided financial asset to the hospital. Today's school in the hospital, with a program that competes favorably in nursing education *par se* with the two-year junior-college program, is a costly operation. Far from saving money, the school now adds to the hospital deficit. The study on costs of nursing education of the National League for Nursing showed the total cost to the school for each student each year to range from \$2,100 to \$2,700. The median value of student contribution to service per year in this same study was \$600. As community colleges develop throughout a state, a girl interested in nursing may enroll and live at home. Her tuition and other charges for the two years will in all probability be lower than those in the good hospital school, which must add to tuition and other costs board and room for three years.

There are other factors. Not to be forgotten at this time is the high prestige attached to a college degree by families who send their daughters to school beyond the high school. That the graduates of all three programs are licensed by the state with the same title, registered nurse, means little.

It might well be asked what the employing agency can expect of the graduates of these three basic programs for registered nurses. Both two-year and three-year programs are planned to prepare for beginning general-duty nursing.⁹ That the three-year graduate has had more time to work with patients and with others caring for the patients during her school years shows in her more rapid adjustment to the responsibilities of graduate-nursing practice. That the graduates of the junior-college and baccalaureate programs on first employment need more time to develop skill in nursing technics and in the application of their knowledge is to be expected. Sufficient investigation has not yet been carried on that will either show how best to assist the junior-college graduate to adjust to the demands of nursing service or to study how the unique function of the broadly prepared graduate of the baccalaureate program can be put to maximum use in the hospital. In the field of community health there is less confusion, for only the graduate of the baccalaureate program is prepared for work here.

What will happen to the system of educating nurses in the far future cannot now be predicted with any reliability. Pressures from some segments of organized nursing urge rapid movement of educa-

tional programs into the college or university as preparation for a professional nurse. Others, including the hospital and nursing-service administrators, urge retention and improvement of the hospital-school plan to safeguard the system that now furnishes, with the two-year junior-college programs, 90 per cent of the practicing registered nurses.^{10,11}

Preparations for the future of nursing education should not be guided alone by sentiment for old patterns, by uninformed enthusiasm for new or by individual group desire for professional status. Nurses now from all three programs want to nurse patients. Their approaches to nursing care will differ as the doctors' approaches to modern medical practice do. Sometimes their care will be given through leadership of others. To nursing educators belongs the responsibility for planning the educational programs that will develop the skills needed in the practitioner of the future.

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Changes in the Pattern of Patient Care

N. E. Hoff Assn
1965

Only four years ago, participated in panel at this meeting

To draw clear cut picture of patient care in '61 as compared to '65
not really possible - Can see phases of changes and outstanding
events as they appear and merge to influence trends.

Commonly discussed trends in patient care are many and each
creates as it appears a series of ripples. Like proverbial pebble spreads
both the news of its advent and ~~the influence~~ ^{its} gradual initiation of change

Much discussion - over crowding of hospitals - population explosion
Aging population - geriatric care -

Much said of new styles or recent systems of patient care - progressive,
intensive, critical, ambulatory and the demands these create
as well as the benefits they bestow in organization team plan - develop

~~of unit manager to achieve nurse etc. not particularly new~~
At this meeting have only to view exhibits to see the growth of
technical equipment for patient care - monitors, T.V., artificial
pacemaker, breather, and computer - all presumably time savers

all costly, all it would appear at times designed to take the nurse + other worker away from patient or reduce number of contacts 2

Great emphasis on team plan of care - some on the patient as a participant in the planning for his care - on unit management ~~where nurse for nursing~~
Not enough said of the problems of communication with a without gadgets for care - communication between pt - nurse - pt doctor - nurse - doctor et al

All these I review quickly - most often discussed

A review of the literature of the past 4 years in nursing journals. Shows major concerns, shortage or undersupply of nurses and the educational systems involved in the education of nurses

As I read ^{my} concerns increased - because most emphasis on education - education for future nurses.

True need so to plan - renewal is vital, and ^{need for} deeply is critical

No argument about this Education holds one of the 3
most important keys to future - But we must always
work in present, - we live to-day, the patient care is needed
now - I wonder ^{sometimes it is} ~~could we~~ lose the battle for the future
because we drift in the present.

All know. Report of the Surgeon General's Consultant Group
in Nursing - "Toward Quality in Nursing - Needs & Goals."

Was released 1963 - 2 years ago - an important report, of
sufficient significance to form background for Legislative
Action - A report geared to quality in nursing - 57 pages
of which $5\frac{1}{2}$ pages dealt with nursing - entitled "More
Service from Present Resources"

In 1964 the Nurse Training Act was passed by Congress
to help to meet the Country's need - Again all plans were
for education - assistance to students, to schools, project

grants to improve education. What ~~task~~ of the agencies, the
 institutions, the programs in which these future nurses are
 to work. What of the patients who are with us now? What
 about projects to improve their care? How will these ~~nurses~~ ^{students}
 prepared in programs to improve the quality of nursing adjust
 to the services ^{which perhaps} ~~perhaps~~ ^{some a perhaps} ~~or many~~ surely will show
 little change from the 1950's or 1960's. How will the product of
 the progressive educational system fit into the agency operating
 under ~~old~~ to-day's patterns of organization, administration
 and patient care plans? It is not alone the government
 which has kept education and service separate, it is
 all of us in national organizations and individually. Nor
 is it the government alone which looks to education for the
 cure all - it is our national and local organizations and
 too often ~~we~~ represented here too. So patient care receives
 less emphasis, less stimulus to change. Those in education

~~sometimes~~ ^{often} too far away from the patient to plan ^{realistically} for ~~to~~ ^{to} day change. ^{or ways to help to move from to} ~~to~~ ^{to} day plan to a better tomorrow. Those in nursing service too far away from education to feel the stimulus.

There is another gap which influences the slowness of our changes in organization of patient care - Evident at bedside, head nurse desk, hospital admin. office, - every unit in the hospital contributing to the care of the patient.

^{Communications - joint planning - speaks of team of dr. as leader. - But does}
 I refer ~~to~~ ^{to} ~~fact~~ ^{that} as specialization increases in a group the group becomes more & more involved with its own body of knowledge, its own studies, its own progress, its status. The planning ^{for patient care} which should be integrated at several key points remains ~~separate~~ ^{separate} and quite distinct for each group. - a crucial situation for the patient, ^{who must himself then struggle to make an integrated whole which he can understand.} Unless all concerned can plan together multiple goals will be set and conflicts inevitable in education, hospital & health agency planning -

or does he possibly give the order what is his role?

In all fields the practitioners of the future will be different ⁶
and each

For the present I select only the nurse

My nurse of the future may bear little relationship to the
nurse of to-day - ~~Having few nurse will be replaced in many~~
~~ways~~ ~~do not mean need for nurse directed~~
by mechanization - no indeed Nor will she move further

away from patient - in fact may move to the patient
Nor do I ~~enter now to discuss~~ ~~for the educational plans~~ the virtues and values
of the existing ~~systems~~ ^{dep. also BS} of education of nursing. I believe in
all - believe all are needed. To achieve the goal set in the
Surgeon General's report we shall need more graduates from all
schools of good quality and we shall need more schools

I am in a sense discussing the nurse in abstract. In
my thinking is a composite of those who will give nursing
care to the patient, who will plan the care, assign, supervise
evaluate the care of the patient's side. who will be a

be a partner in the patient care team at all levels of patient care planning or giving

She will need more knowledge - not in the sense that every nurse be a college graduate but because there is more for every nurse to learn be she a ^{diploma} practical nurse or a supervisor - all patient care will be more complex -

She will need ~~to have~~ ^{a better} more psychological and sociological background to deal herself with the stress of community living and to help the patient to do so too

She will be less involved in the business of assisting hospital administration with requisitions, charges, and ward administration and more involved in the administration (narrowly or broadly) of patient care.

She will need preparation to understand and use ^{to understand patient physical, psych- & social reaction to} technological devices, to study problems of patient care ^{their}

to do research to revise the present practices + make ready for future
She will participate in continuing programs of education
which will help her to improve the present and plan for the future

The nurse will show new characteristics -

In her patient care, she, the doctor, the patient will
~~see her as~~ recognize the nurse as possessing an
independent function as definable and distinct from that
of medicine

include jts
phys - eyes for blind
log for laws etc

There will be developed in large numbers + many different
ways - the clinical specialist - some times defined as one who
concentrates on integrating, understanding, supervising and
coordinating the clinical activities at patient ^{side} - a role which
can change a multidisciplinary mélange into an understandable
therapeutic plan for pt

to be considered to be the first of its kind in the world
which will participate in certain programs of education
which will help us to improve the present and give the future

the course will show new characteristics
in the present case, for the first time, the patient will
see how the course is progressing and
independent of the course as a whole and the details of the
of the course

the course will be
the course will be
the course will be

then will be involved in large numbers of very different
ways. the course of study is now being defined as the
the course of study is now being defined as the
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The nurse will have a new relationship with ~~medical~~^{doctor} & hospital

Recognition of her independent responsibility

Relinquishing of non-nursing functions to others
(more than now)

A concentration of nursing

A research worker in her own field adding her contribution
to developing new patterns of care

She will ~~advance in pt care~~ ^{not only by moving}
Composite role - bedside nurse ^{is admin} with ^{knowledge} understanding &
judgment needed to evaluate, plan, modify as does physician
in his field - ~~to be~~ an administrative nurse returning
to the patient ~~to~~ not to carry out detail of care
but to see that care is given

Make rounds - ascertain needs

Assign & carry out herself

Supervise

Supply thread of continuity through maze of procedures and tests

Reaching out into community & nursing home

Mr Pellegrino writing in Hospitals makes the statement that the patient is more concerned with what the nurse is to him than what she does in way of procedure.

This relationship should be also true between nurse & doctor for doctor & when true hosp administrator must see the emerging role of the nurse & allow her to fulfill it. Support not resistance will ~~stimulate~~ make the supply of

Make answer - answer needs
 reason & copy out himself

Shakespeare
 Shuffled third of century of Shakespeare

and trials
 leading out the country & home, but
 the religious movement in the 19th century was the statement
 that the point is more concerned with what the man
 to him than what he does in a way of procedure.

Other relationship, it will be also true between various trials
 for better & under the best of circumstances must be the
 changing, and of the man - allow for the fulfillment of the
 not resistance will be the fulfillment of

nurses more adequate and stimulate the initiative & imagination. Then in 1970 if this organization should again review patterns of patient care Nurses & Nursing may ^{show significant} ~~have~~ a contribution

1. How better understand need for nurse-pt (or
How plan to organ & prep for future
2. How get phys more intell into act -
? didn't b approach
3. -
4. ? comfort role of contr to pt - nurses' sufficient
of pt - emotionally etc

Can we diff - nurse & med care

Can we bring nurse back to pt - how prepare

How get nurses to be experts in pt care

CHANGING PATTERNS OF PATIENT CARE

To try to describe the changing patterns of patient care in this era is like trying to describe the patterns on the waters caught in a whirlpool - now seen, then gone; now in multiple ripples, then in one vast wave; buffeted by currents from beneath and pushed this way and that by the on-rushing stream.

For the purposes of this discussion let us try to concentrate our thoughts on three major factors most intimately involved as patterns of patient care change: the patient, the care plan, the nurse. Or, we might broaden these three to read: the patient, his needs and expectations; the care plan as affected by changing social and medical trends; and the nurse with her evolving role.

It is not easy to look at a group of patients in a hospital ward or in a clinic today without wondering what has happened to "the good old patient." It is not merely a matter of age, although the age difference is striking. It is not because of the difference in the disease condition which brings him to the hospital. To be sure the number with infections is fewer and the number with the degenerative diseases is greater. Nor that the patient of today feels a new security in his hospital insurance plan, and so may come to the hospital more readily and more often. It is not just that few patients on the wards remain in their beds. It is not just these differences. There are others which doubtless have always existed, but which today become almost universal among patients and influence all phases of the care as well as the individuals who participate in the care.

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idea of the "primitive" is a new one. It is
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ways. It is a term which has been used to
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it is not always clear what it means.

First, there is a difference in the knowledge which the patient brings to the hospital. A short time ago a student in our School of Nursing was to admit a patient. This patient had had a previous hospitalization. The student went confidently into the room saying, "Good morning Mrs. X, I have come to admit you." "That's fine," said the patient, "You just sit down right there and I'll tell you how we're going to do it." The student did and the patient did, and the student learned two valuable lessons. First, that patients are often not only very knowledgeable but that today's patients increasingly feel they have a right to participate in their own care. True, the knowledge they hold may not always be based upon sound scientific fact, and the patient may dominate the care plan to his own detriment. But, the fact remains that newspapers, magazines, radio, TV and other available media are fast bringing knowledge of health and disease to our public. We who would work constructively or teach must realize that the patient has acquired a new power for cooperation and a new basis for anxiety. Today's patient is a different person. Moreover this more knowledgeable patient wants and feels he is justified in demanding his share in the plan for his care. Because he has made a plan to finance this care now he wants to know what should be done and how. Furthermore he wants in on the decisions. He needs a different kind of nursing care.

In contrast to the patient of 25-30 years ago, today's patient knows that the care begun in the hospital does not end, or should not end, when the good-byes and good wishes are said at the hospital door. In fact, the hospitalization period in one sense may only be the beginning of a new life inextricably bound by the new medical findings and governed by the information carried home by the patient. Patient care trends move more and more toward a pattern of continuous progression: from hospital to nursing home to his own home to industry or school. This

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progression of course may be in reverse too. The patient learns where care, support, and teaching may be found, and so sets up for his own personal needs a cycle of care like a protective sphere surrounding him to keep him safe from sickness, but equally important in enabling him to be a contributing member of society regardless of old age, or crippling handicap, either physical or emotional. In this protective sphere a different kind of nurse will be needed.

In short, the patient wants to be an active member, a participant in the health team, and he expects this team to be available always, each member of the team in fact available at different times to meet his specific need. It is also significant that the number of such patients continues to multiply.

So the plan for care of the patient of the future will be influenced first by the patient himself as he changes with the times. Other factors in the changing plan are well known to you all. It is no longer enough for the nurse to see a patient in cardiac distress, to raise the bed, take the pulse, give emotional support and wait for the doctor. There is the pace maker to be attached, closed cardiac massage to be started if indicated. The drug added to the intravenous infusion may require regulation as blood pressure changes. Pharyngeal or deep suction may be necessary. Oxygen can be started. Tourniquets or sometimes electrodes may need to be attached. Today nursing involves observations as always. It requires emotional support as good nurses have always given. Today there are new and critical decisions added - a matter of judgment, a matter of more independent action, changing the care plan until further directions can be secured from the doctor.

Nursing care is no longer a matter of doctor-nurse interaction only. Special consultants, technician, social worker, dietitian, oxygen therapist, physical therapist, occupational therapist and many others share with the nurse.

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Nursing care is no longer a matter of doctor-nurse interaction only. Special consultants, technician, social worker, dietitian, x-ray therapist, physical therapist, occupational therapist and many others share with the nurse.

Nor does the nurse do all the nursing. Nursing care given by others must be planned and taught and directed by the nurse. A co-worker with the doctor, true of course, but also today's nurse must, if the total care plan is to be accepted by the patient, be a coordinator for many different workers, professional and non-professional. Someone always present, someone who understands the essentiality of all aspects of the care plan, must coordinate the many facets of the plan into an effective whole which the patient accepts and to which he submits because he understands the purpose of all the parts.

The question we in Nursing face is how does the nurse fit into this changing pattern of care, and what happens to the nurse during this process of change. Some of you will remember the so-called "good old nurse" who supposedly only took orders and carried them out. Her whereabouts is often sought today by public and medical staff alike. It is interesting to speculate what would happen if today's nurse suddenly reverted to this good old role. Or what would happen in our hospitals and public health agencies if the nurse of today were to fulfill another common expectation and remained with the patient at the bedside. Or what would be the consequences if the hospital nurse attempted to fill the role advocated by some educators, giving expert comprehensive care to a few patients, ignoring the broad community need for care for the rapidly increasing number in our population who need nursing care.

What will today's or tomorrow's nurse do? What role will she choose? How will she adjust the conflicting expectations that she may work without abnormal or detrimental tensions? Will she find a role which will be primarily hers? Will she be able to adjust this role with the changing social and medical trends, relinquishing activities to others in the nursing team, safeguarding the patient by her planning and oversight, adding activities and responsibilities as medical

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patterns change, but keeping the patient and family as the central focus, seeing that he has help to function when unable to do so alone on his own, and to assume normal functions as fast as physical and emotional condition and medical plan permit.

Obviously the nurse's role cannot be expanded ad infinitum. It can be modified. Much more can be done to relieve the nurse of non-nursing functions. Much more can be done to introduce mechanical devices which save time and add efficiency. To speculate on automation brings both tremendous hope and a rather bewildering apprehension. I quote from an article on Automation in the March, 1961 issue of the American Journal of Nursing: "In this (imaginary) hospital each patient lies in his own cubicle, and there are attached to him all kinds of wires, connected to his brain, his muscles, his viscera. These wires or electronic pick-ups transmit signals to a computer when the bladder is too full, a bowel is stuffed, the patient is hungry or in pain. Then the computer sends signals to different kinds of apparatus which empty the bladder and bowel, fill the stomach, scratch the itch, massage the back and so on. We could even mount each bed on a slowly moving belt; the patient gets in a bed at one end and four or six days later his bed reaches the exit and the patient is healed."

An imaginary picture indeed! One we hope we shall never actually see or experience. But, automation is here in this world of physics, and the nurse, the hospital, and I hope most of all the patient should benefit whenever the automatic device can be used to advantage. Why should nursing personnel wash equipment in a utility room in these days of dishwashers, any more than we wring hot packs by hand with old fashioned ringers. If medicine dispensers can be made

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to be used in the utility room, why should the patient be asked to wait in the waiting room, waiting for the nurse to get the medicine and give it to him?

practical, why should a nurse count out pills or measure liquid doses of medications by tens or twenties or hundreds in a day? If a machine can report vital signs accurately and adequately why should nurses take blood pressure and pulse every fifteen minutes on innumerable patients in a twenty-four hour period? If a machine can prepare all the necessary forms for an incoming patient with one quick motion, why should the nursing personnel write out and assemble the record? You can add more automatic devices to my list now and the days ahead will increase the possibilities. Perhaps when technicians and/or maintenance men can be found to keep all of these machines in continuous working order, nurses can nurse a little more, and can fulfill the role which they expect and want. The difficulties as I see them will come with the acceptance of automation at face value with no evaluation of its usefulness and no plan. It would be unfortunate indeed to remove non-essential activities performed by nurses to give them to a machine and then to replace them with more non-essentials or to leave a void, a wasteful situation.

There will be other necessary changes too. Amongst these will be essential and radical changes in the administration of nursing care. From discussions of late years one might have concluded that the employment of nursing auxiliaries and a little instruction on how to be a team leader was the necessary panacea for all nursing ills. Unhappily this has not proved to be so. Yet the team concept has value in the administration of patient care.

Now we hear of the "skill hierarchy," a horizontal progression of the nurse as skill develops. This plan we are told provides the clinical nurse specialist, safeguards the nursing skills for nursing, avoids loss of nursing skills by providing opportunity for horizontal promotion rather than vertical promotion into administration. This plan can be made a valuable one too, but no single modification will be enough alone.

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All such plans, and more to be envisioned, see the nurse as administrator of nursing care, not as administrator of a ward; as a head nurse of nursing, not the head nurse of a ward unit.

The story is told of a little boy walking with his father. "Pa, what is electricity?" said the boy. "I don't just know son," was the father's hesitating reply. "What makes a radio go pa?" "Well," said the father, "I never did just understand about radio." "Pa - oh never mind." "Now son," said the father firmly, "You just go on asking questions now. How are you ever going to learn anything if you don't?"

Well might we ask "What will the future hold for nursing and nurses? Who will fill the nursing role? What will the nurse do?" Perhaps like that father we might hesitate to give a firm answer upon which judicious planning could be based. There is certainly little firm beneath the whirlpool of change in nursing except people. No matter what may come, it is safe to say people will continue to be patients, and patients will need our care. Today's challenge is to catch onto the trends of the various currents within the changing pattern that we may move with them, or because of them, secure in the knowledge that the good nurse, such as Miss Alling whom we honor here today, will never founder.

Ruth Clapper, R.N.
Director of the School of Nursing
and Nursing Service
Massachusetts General Hospital

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Director of the School of Nursing
Massachusetts General Hospital
Boston, Massachusetts

ORGANIZING TO ACHIEVE PATIENT CENTERED OBJECTIVES
IN BOTH NURSING SERVICE AND NURSING EDUCATION

The title given me for this afternoon is an interesting one, filled with implications. It implies that patient care should and can be planned, and planned specifically in terms of the individual patient. It says there are to be objectives to guide the planning and implementation of patient care. It indicates that nursing service and nursing education do or will work together to achieve a goal. Not a simple series of statements, yet if we follow through such statements they may produce positive results and bring forward looking changes to our patient care programs.

Because this topic is at the very core of my own interests at home, and because we are all involved in a new approach to the problem, I have tended to use my own experience in approaching this discussion. First, as I consider steps to be taken I need to be sure all involved are talking the same language. In my own pre-planning I should look at the words in the title which in reality form my objective for whatever action is to be taken. I might word this objective as follows: to devise and put into effect a plan of organization which will bring about the use of patient centered objectives in both nursing service and nursing school programs. This objective indicates that I have three steps to take. The first is to devise a plan for the use of patient centered objectives. The second is to assure understanding and acceptance of the plan. The third is to formulate the steps necessary to bring the school and service together to work on common areas of planning and organization, and to secure the cooperative action which will enable each to support the other as appropriate.

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same language. In my own pre-planning I should look at the words in the

title which in reality form my objective for whatever action is to be taken.

I might word this objective as follows: to devise and put into effect a plan

of organization which will bring about the use of patient centered objectives

in both nursing service and nursing school programs. This objective indicates

that I have three steps to take. The first is to devise a plan for the use

of patient centered objectives. The second is to assure understanding and

acceptance of the plan. The third is to formulate the steps necessary to

bring the school and service together to work on common areas of planning and

organization, and to secure the cooperative action which will enable each to

support the other as appropriate.

Now I should expect the school faculty to be quite at home in discussing objectives. They will turn naturally to the school's philosophy to test the suggested plan against both philosophy and current objectives. The nursing service will be less at home in this area. Several years ago our own nursing service reached the stage where a philosophy or a statement of beliefs was felt to be necessary. We believed such a statement would help to assure a common understanding among the members of our nursing service group. The statement of beliefs formulated both supports our planning and guides our action when new problems arise. It is simply stated. It is known not only to the administrative members of the nursing service but to all employed personnel. In our plan the statement is prepared and agreed upon by the leaders, then through continuous interpretation is made known to all who join the staff. We hope by this approach to make it understood and accepted by all, regardless of the level of responsibility. It is also a part of the nursing service program to review this statement periodically and readjust it or revise it as necessary.

Let us presume for the sake of this discussion that the philosophy of the nursing service like that of the school is already prepared. As I make my plan I look at the two. The statement of the school is expressed in educational terms, it is pointed toward an ideal, it looks to the future, indicating that today's student will be prepared for tomorrow's nursing. The nursing service statement of beliefs is realistic in terms of need, down to earth in the simplicity of wording and reflects today's demands and complications in a situation with highly diversified groups of personnel involved in various aspects of patient care. The nursing service statement focuses more on today's situation, but it is none the less forward looking.

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There are those who say the ultimate aims of both school and service are the same. You, as I, may hold a different view. These differences should be recognized and accepted by both staffs, the school and nursing service. First, the philosophy of the school is geared to the future, that of the service to the present. The school focuses on people sick and well in all situations and conditions, the service on the care of the sick in the hospital. The school plans for teaching and student learning. The service for administration and the employed worker. Obviously such differences are correct and should be accepted as right.

Objectives are of course derived from philosophy. As we turn to consideration of these we should as before expect the school and service objectives to differ. There may be common ideas involved, but the ideas will be expressed to suit on the one hand the learner and on the other the worker and patient, a significant difference.

There will be areas common to both school and service, first the problem solving method will be needed by both groups, and second, the expected outcomes, or the care resulting from the use of patient centered objectives. Here again the teachers who see the problem solving approach as a part of all teaching and learning will have the advantage. The graduates of progressive schools of nursing will be acquainted with the method. Whether they will use the method with ease in the work situation, whether they will approach patient care habitually using this method will depend on how much a part of their thinking and working this scientific approach has become. It is my impression that the nurse graduated even a few years ago, or the nurse who has been working in a service with shortages and pressures, may not use this problem solving approach at all, or find it difficult to apply. In fact many nurses, the practical nurses and auxiliary workers, will need to be taught, will need to

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learn such an approach, and helped day by day until this pattern of thinking is a well developed habit.

The "good old nurse" and the "good nurse of today" may actually use the problem solving approach but may not identify it. They observe the patients' need and reactions, the search for ways to meet them, and they find a solution which meets the need. Nothing new - just good nursing and they enjoy working with patients this way because patients respond so well to the care.

Let me quote just a few lines, only a small segment, from a nursing care plan to illustrate my point. This patient is aged 10. Her diagnosis is "multiple sclerosis." She is uncooperative, resistant to doctors, nurses and others. Treatment is unsuccessful, even minimum care is difficult.

The form on which the nurse wrote has these headings:

on the left Problems observed

1. Spoiled by parents and grandfather

2. Antagonistic toward staff. Answers everything with "no."

3. Impolite and rude toward staff in presence of parents.

on the right opposite Approach

1. Do not interfere with the family relationship except when it concern essential care.

(Assume a realistic attitude)

2. Appeal to child's nature and pride. Make sure her reluctance to do something reflects no negative emotional reaction on nurse's part.

3. Meet "abuse" without any display of emotion. Be exceptionally polite, firm but kind. Avoid role of disciplinarian. Child soon

is a well developed habit.

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[illegible]

presence of parents.

ceases to fuss. Keep child
diverted.

Nursing Care Objectives:

1. To wean child away from a demand for special attention and to help her adhere to plans made for her as easily and effectively as possible.
2. (Follow doctor's line of least resistance toward changing Jane) To develop rapport with Jane which will give child confidence in her care and in personnel.
3. To ambulate Jane in such a way as to avoid pain and emotional upset.

Now this, some will rightly say, is only good old fashioned nursing, a simple statement of an understanding nurse. And so in part it is. But it can be far more. The nurse has first identified some problems, some areas in the patient's reactions. I have taken only some of the psycho-social ones. There would also be physiological reactions to study and to include. The nurse who asks what are the patients particular or individual reactions to the environment to people, to disease et al, the nurse who questions what the patient is trying to express, who looks for the unmet need is on her way to the problem solving approach. She will proceed to identify the problem and to gather all possible information from observations, conversations with patient, family, doctor, co-workers and records. She will then sort out her knowledge to get a hunch, an hypothesis, and put this into form. Then come her approaches to the problem to be tried out. When they are finally adopted as a plan, others may also follow. Complicated? No, not once the method of thinking becomes a natural part of the nurse's action. Just as the portion of the care plan I read a moment ago was extremely simple, beginnings can be simple but can

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at the same time alert others including practical nurses and auxiliaries to approaches suited to the patient's needs. In this instance those concerned with the child's care followed a consistent pattern of action. The calm, firm, but kind manner served also to calm the child. Her response to her care gradually became more cooperative. Her whole tone was more relaxed and her comfortable moments more enjoyable. So the family was also helped.

Doesn't a care plan take too long to write? This of course will depend upon the plan. It is probable that plans written by students may be more inclusive or written more fully. The nursing service staff may question why a plan should be written at all. Today where patients are cared for by so many different nursing personnel with so many different types of preparation the written plan seems the only answer. Patients are confused when every member of the nursing staff makes a different approach. Patients often must be exhausted repeating the way they like to be moved or positioned, or fed, or even to have the room cooled at night. Why should we expect this of the sick or weary when a brief note in a care plan explains the deformity or the pain which makes one position more comfortable? Is this not our responsibility? Once established, if sufficient importance is given to the care plan, all members of the staff will find values in it as a nursing tool, not just a learning process through which the student must pass in her progression through the curriculum.

Conceding that nursing care plans are essential to good or individualized or comprehensive nursing care, how do we proceed to organize, to achieve the objective. Let us now consider this point for a hospital school of nursing involved with a hospital nursing service. I am not purposely omitting the university or junior college program. Only one type of program can be dealt with at a time, and I believe whatever discussion clarifies the situation within the hospital can be adapted to any nursing education program coming into the hospital to utilize the nursing units for field experience.

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First, the title implies separate units functioning for the nursing education and the patient care programs. I would therefore expect that in hospitals conducting schools of nursing efforts might already have been made to identify and separate those functions concerned with the educational program from those carried on primarily for patients or personnel. There are many values derived both during the process of identification and separation of functions, and from the plans later evolved. From the vantage point of the school of nursing first the educational program can be planned more adequately to meet educational objectives; second, the school staff can concentrate with fewer distractions from patient care concerns; third, students themselves are stimulated by the priority given to their learning needs. From the service point of view, the situation is not dissimilar. First the nursing staff will have more time to devote to patient care, and second, the staff can concentrate on present and anticipated care problems and their solutions. An additional factor is sometimes overlooked. When service and educational functions and responsibilities were not separately defined and assigned, there was a tendency for nurses with better educational backgrounds to gravitate toward or be guided into the few existing full time school positions. There seemed in such positions more opportunity; more challenge. There was often more status given. And of equal importance there was actually higher salary. Nursing was saying and saying very clearly that education was more important to the profession and that those who went into nursing service were second class citizens. You may feel that I have over-emphasized this point. I do not believe so. I believe the feelings aroused in the past tended to weaken our nursing services. In fact it is possible that such feelings have been in part responsible for the lack of prepared administrators and supervisors today.

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and I believe that the nursing school should be a part of the hospital program and the hospital can be helped in any nursing service program which is beneficial to utilize the nursing school for their convenience.

So I would look first to the identification and separation of nursing education and nursing service responsibilities. I should perhaps stop here to say that such separation must not remove all responsibilities for education from the nursing service organization. The nursing service which sees its full range of responsibility includes the teaching of patients and families, the teaching of employed staff that there may be constant growth to do the job and the consideration of the patient care unit as a suitable practice field for nursing school, medical school, intern and residency programs and for any other group coming to the ward to learn.

How can we organize the staff of the nursing school and the nursing service with their differences and similarities so they may work constructively together? Is it a matter of communications? Yes, some formal, some informal, but all according to an agreed upon plan. Those with major responsibility for the two programs must first take responsibility to formulate a plan. To drift along will inevitably bring dissatisfaction, friction, lack of cooperation. It is at this point the philosophies, objectives, defined functions, designated authority and responsibilities must be presented, discussed, understood, and finally accepted. And this acceptance must be with respect and a willingness to try to make the trial plan for cooperative action work successfully. There must be interest in evolving an organizational structure for cooperative action, a willingness to work - perhaps to suffer a little in the disagreements or in giving up cherished ideas - as the plan is made, an openmindedness toward each other's plans and the opportunity to express different opinions without criticism. The school must respect the right of the service to set its standards, to hold contrasting beliefs, and to work in the way its members choose. The nursing service on the other hand must see the school's differing objectives and methods as growing out of a different responsibility.

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The organization finally selected to bring continuing action must be planned to fit the individual situation and the individuals in that situation. There must be an organized group of those from both school and service who carry major responsibility. This group in accepting responsibility for the plan must see this as a continuing obligation, not one accepted for the moment only. This organization may be called a joint committee, a council, a coordinating council or by any suitable name. The rules for its operation should be simple in form and agreed upon early. The objective of cooperative action in areas of mutual concern should stand foremost. The committee should not be an administrative committee. Both school and service must retain the authority and responsibility for action in their own areas. When action is needed each group should assume its own appropriate administrative action.

Once understandings are reached and agreements are made this joint committee can then lay the ground-work for interaction at all levels of school and service contacts. To have understanding and cooperative action at the top administrative level is not enough, if head nurses, supervisors, and teachers are left out. Head nurse-supervisor meetings to which teachers go periodically but regularly and in which all participate equally must be planned. Clear identification of authorities and responsibilities will be essential here. Periodically new material will appear to provide interesting agenda for such meetings - curriculum changes which modify the pattern of student practice - new personnel, new practices in nursing which affect the student's need for learning.

Perhaps in this area almost more than any other is the need to recognize and clarify misunderstandings. Nursing education has moved with unexpected speed from dependency on hospital patient care alone to a new and radically different approach to learning. Head nurses, supervisors and others associated with teachers and students in the patients' area have been left

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without understanding of the change, or faith in the anticipated outcomes. Meanwhile, the nursing service staff has found itself faced with increasing demands from a community larger in number and greatly augmented in expectations. It is not alone that there are more and more patients, as there are. It is that more patients want more and more care, a kind of demand constantly undergoing a square root increase. The school can decide on the number of applicants to be admitted in each class and can seek its teachers. The nursing service which tries to curtail the number of patients is running contrary to a community need. The nursing service cannot with any assurance plan for numbers to be cared for or type of care to be given. Even less hopefully can the nursing service recruit the necessary personnel.

Yet there exists in nursing service a desire to know and to carry on in the best possible way. So meetings must be planned and carefully structured for and by head nurses, supervisors, and teachers to share philosophies and objectives as the joint administrative committees share theirs. In addition and more important for this group is the need just discussed to share information on trends and phenomena associated with each.

Sometimes I look at the university school dean and wonder if she realizes how different her task must be. She may believe she wears two hats, one to meet the university's academic requirements, one concerned with the advancement of nursing education. But her hats are in a true sense both academic - both concerned with education. Both hats may be pinned on with the same pins and each supports and strengthens the other.

We in hospitals wearing a cap for nursing service and a cap for nursing education may appear to be wearing a single cap - a nurses cap. If this is true, my cap and yours certainly rest on two different minds, one

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We in hospitals wearing a cap for nursing service and a cap for nursing education may appear to be wearing a single cap - a nurses cap. If this is true, my cap and yours certainly rest on two different minds, one associated with teaching and education in the hospital, one with the association with research and education in the university area have been left

influenced by desire for the best in education, and one torn by desire to fulfil patient needs. Ours is the task of a juggler trying to steady the two when imbalance comes. Perhaps, however, we can build a bridge between these two minds by building an organization which sees both the objectives of school and service, and seeing draws the two groups into cooperative action, the objectives to be achieved.

There are today 883 schools¹ which grant a diploma in nursing. With very rare exceptions these are operated by hospitals. From them are graduated nurses prepared to begin work as staff nurses in general, obstetrical, children's and psychiatric hospitals. They are also prepared to work in doctor's offices and, after some experience in staff nursing, as private nurses.

Approximately 82.5%² of the 31,186 nurses graduated from all basic nursing education programs in 1961-62 were from diploma schools. The geographic distribution of these schools shows a higher proportion operating in the North Atlantic area. Here 318, or 37.3% of the hospital schools enroll 36,850 or 29.9% of all student nurses in the 1,126 basic nursing education programs of all types in the entire country.³

It appears of some significance that where this higher proportion of hospital schools exists, with its larger enrollment, there is also a higher ratio of nurses to population. In 1962, the New England States had 416 nurses per 100,000 population, the highest ratio in the country. The Middle Atlantic States, including the District of Columbia, were next with 368 nurses per 100,000.⁴

That the diploma programs of the hospital schools of nursing stand today as the major source of nurse supply for the country's hospitals does not ipso facto indicate that this form of nursing education is always to be preferred, or that it is the only form of nursing education which can or will prepare nurses to meet the nation's need for nursing.

1 Today's Diploma Schools of Nursing, p. 66, table 1; National League for Nursing Inc., New York City

2 Ibid., p. 66, table 1

3 Ibid., p. 66, table 2

4 Toward Quality in Nursing, p. 8, table 1; U. S. Dept. of Health, Education and Welfare

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It appears of some significance that where this higher proportion of

hospital schools exists, with the larger enrollment, there is also a higher

ratio of nurses to population. In 1962, the New England States had 116 nurses

per 100,000 population, the highest ratio in the country. The Middle Atlantic

States, including the District of Columbia, were next with 108 nurses per

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The diploma program does have strengths. It provides an education for nursing at lower cost to the student and her family than many four-year programs and some two-year programs.

It permits a shorter period of education as compared to the baccalaureate program for the girl who wishes to, or must, become self-supporting as rapidly as possible, or for the girl in whose vicinity there is as yet no community college program in nursing.

It enables a student to move rapidly from classroom into student nurse practice in patient care, and so meets the objective of the student who is impatient to get to "nursing" or less interested in a long period of study in the humanities.

It attracts the larger number of applicants, and so is of significant value to the country's health program. In 1961, 38,257 or 76.3% of all applicants admitted to all schools of nursing entered schools conducted by hospitals.¹

Those who conduct diploma programs have struggled against persistent weaknesses since nursing schools were first opened in this country:

1. The student nurse was accepted by hospital administration and medical staff as a source of cheap labor.
2. Money was lacking for education. Schools received no endowments. The only source of support was through the hospital's per diem charge to patients.
3. The primary objective of most hospitals is patient care. Education followed therefore as a secondary interest.

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Those who conduct diploma programs have struggled against persistent

weaknesses since nursing schools were first opened in this country:

1. The student nurse was accepted by hospital administration

and medical staff as a source of cheap labor.

2. Money was lacking for education. Schools received no

endowments. The only source of support was through the

hospital's per diem charge to patients.

3. The primary objective of most hospitals is patient care.

Education followed therefore as a secondary interest.

4. The educational program in the hospital school though greatly improved continues in a service-centered organization and can provide only a narrowly professional curriculum in contrast to that secured by her co-workers in medicine, social service, dietetics, et al.

Trends in education for American youth have also influenced interest in the diploma program. Today the average family looks avidly at a college degree as a source of improving social and economic status.

Changes in college curricula, resulting from a variety of reasons, are today hindering a diploma graduate who wishes subsequently to secure a degree. The amount of credit allowed by colleges and universities for the diploma program is steadily decreasing.

Even the Associate Degree in Nursing, granted by the community or junior college, in many eyes has value beyond the hospital school diploma, although the diploma may represent a richer, more varied, deeper education in nursing per se.

1

The nation needs nurses. There are now 569¹ diploma programs which through the process of accreditation have been found to possess sound standards of education, facilities to implement such a program, and support from the parent institutions which assures continuing growth. These schools hold great potential as a source of supply for nurses to meet the goal set by the Surgeon General's Consultant Group on Nursing.²

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2 Toward Quality in Nursing, U. S. Dept. of Health, Education and Welfare

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PROBLEMS FACING NURSING IN THE UNITED STATES

The problems which have faced Nursing since 1941, and those which will face Nursing in the foreseeable future, have been summarized over and over again. Nursing has been faced by the many forces created by: the expanding population, the growing proportion of older and younger citizens, the rapid accumulation of new scientific and medical knowledge, and the augmented demand for care in health and sickness. These, with other influences affecting Nursing, have been cited and studied by interested nurses, doctors, hospital administrators and trustees. They have been of concern to educators and community leaders. Indeed, I might do well to confine my discussion to these same factors today. The fact that I fail to emphasize them neither marks them as insignificant in my thinking now, nor indicates that they will not continue to complicate our future planning. It denotes only that I believe there are other influences less often discussed which may bring equal or even greater pressure on Nursing's ability to determine clearly what its future course should be.

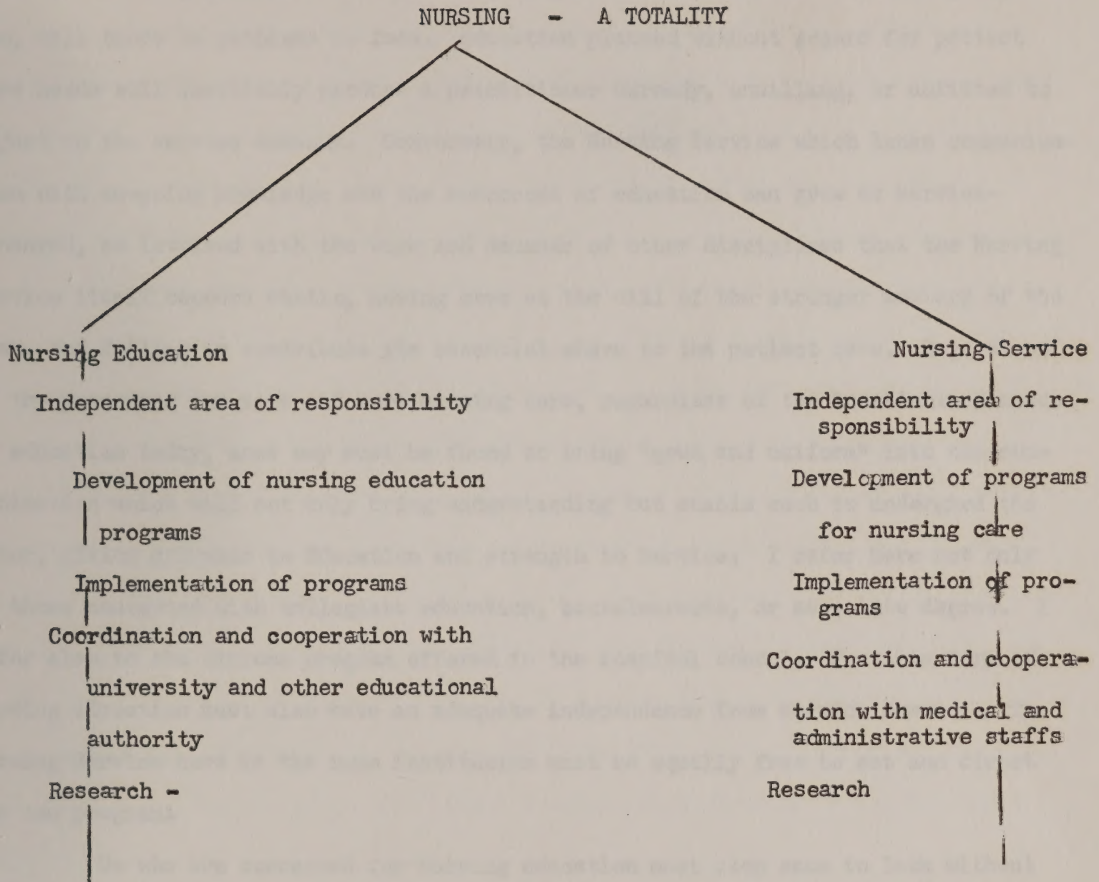
Regardless of our beliefs one thing is certain: whatever we are attempting today to assure care for the people of this nation will not be enough to meet the future need. History shows clearly that each succeeding decade surpasses its predecessor in the number and complexity of its demands.

Nursing education and modern nursing in the United States is now over ninety years old. In its beginning there was no separation between the plan for training of the nurse and the plan for patient care. Nursing was a totality. The pupil, as she was called, nursed and q. e. d. she learned. When she needed to learn she was assigned to nurse. Neither nursing education nor nursing service had well delineated program or plan. The hospital needed young women and young women came to fill the need. It was a simple solution to a simple situation. And, since the plan also supported the economic position of the hospital, the doctor, the hospital directors, and the community as represented by trustees and patients, the plan was deemed good.

Nurses, however, were not satisfied. To be sure there was no imbalance of supply and demand before the twenties, because the products of the early schools were employed in the homes of those who could afford such care. But slowly other forces were felt. Leaders in Nursing recognized the extravagance and the inadequacy of the apprenticeship method. Advancing medical science made greater demands upon the nurse for knowledge than the apprenticeship system could supply. Changes in society as well as in medical practice created ever greater need for numbers of nurses in hospitals and other health agencies. The production of more nurses required larger schools and more teachers. And, finally, the changing pattern of education for American Youth created a desire in the nursing school applicant to seek education beyond that possible to offer in a hospital-conducted school of nursing. Applicants to schools of nursing turned to the universities where education took precedence for the nurse student as it did for the medical student, the social worker, the dietitian, and therapists in specialty areas.

Education for nursing had become, in whatever school it was found, a separate entity, distinguishable from nursing service or patient care by a different philosophy and by objectives specifically related to a student-centered curriculum. The totality that was nursing was broken apart, each severed part striving to find its own place. Each having lost something of value, but too concerned with new-found responsibilities and opportunities to be fully aware of the loss.

If I had a blackboard I would draw a simple scheme to illustrate this relationship.



The picture I hope will be evident - a roof to the structure that is Nursing - two walls but with no substance between, no established means of communication which would enable both education and service to fulfill the daily requirements, and to plan jointly for common change and growth when appropriate.

All of the results of this separation have not been bad. Education has had opportunity, unfettered by demands for service, to develop its curricula. Nursing Service at last has found its own ego, and can see its strengths, its needs for leadership, and its evolving program in the light of its own distinct and equally significant philosophy.

As long as this structure of Nursing exists as a divided structure, so, too, will there be problems to face. Education planned without regard for patient care needs will inevitably produce a practitioner unready, unwilling, or unfitted to adjust to the service demands. Conversely, the Nursing Service which lacks communication with on-going knowledge and the resources of education can grow so service-centered, so involved with the work and demands of other disciplines that the Nursing Service itself becomes static, moving more at the will of the stronger members of the team, and failing to contribute its essential share to the patient care. Regardless of the pressures for more and more nursing care, regardless of the insatiable demands of education today, some way must be found to bring "gown and uniform" into the communication which will not only bring understanding but enable each to undergird the other, giving guidance to Education and strength to Service. I refer here not only to those concerned with collegiate education, baccalaureate, or associate degree. I refer also to the diploma program offered in the hospital school. For this form of nursing education must also have an adequate independence from service demands. The Nursing Service here in the same institution must be equally free to set and direct its own program.

We who are concerned for nursing education must stop soon to look without prejudice at the red lights on the road leading to this future. It would be far better, far smarter, if we could cease our arguments about the professional status of the nurse, or where the nurse should be educated, and focus our attention on what nursing care the patient is to need, and what the nurse must know and do to provide this care. The country's need for nurses tells us that all schools of nursing should be encouraged to expand within sound limits as set by the availability of teachers, facilities, and applicants. There is no question of the validity of this need. The question is where will these young women and men, with their varying abilities, choose to go; where can they make best use of these abilities; what education will prepare each one best to contribute to and find joy in the life which lies ahead.

Where these young people choose to prepare will not be our decision. There is a tidal wave moving toward us who support these nursing programs. Caught up in this wave is a force impelling more and more of our youth to seek the values of education beyond the high school. Propelling them along is a new and radically different system of education apparent now in both primary and secondary schools, the new patterns of teaching which influence patterns of learning and thinking; the advancing level of learning beginning in the earliest grades. Who knows what the graduates of our secondary schools will know and be able to do with their minds ten to twenty years from now? Who can say now how the diploma school, isolated from this stream of general education, can keep in step, can modify its program to challenge this new student, and simultaneously meet the advancing system of medical care. I do not question whether the diploma school will survive. I do question by what means the diploma school will meet the demands for teaching which the new students will make. I wonder how the diploma school can expand its program to provide the science basis the nurse should have in the future medical program. I pause seriously to consider how all that can be done while enrollments in schools are being increased. I cannot say who will finance such a plan. I see in this area a problem which faces us today, but which tomorrow will force us to resolution.

Let us return again to Nursing Education and Service and consider yet another problem, the supply of leadership. One of the greatest deterrents now and perhaps in the future to the rapid expansion of existing schools or to the development of new schools is the lack of prepared teachers of nursing. However, this supply is growing slowly. The shortage of leadership in the Nursing Service should be viewed with real alarm. For what value is good education in the classroom if the clinical practice field does not enjoy the supervisory skills necessary for sound organization and good patient care? The shortage of supervisors with the knowledge and skill to develop a staff adequate to meet the needs of today's medical service promises many problems for the future. Why do nurses going for advanced study not choose to get the necessary preparation for hospital nursing administration and supervision? What

answer can be found in the hospital as compared to the school of nursing, or the hospital as contrasted with the field of public health? The nurse in educational administration, finding her philosophy in harmony with that of her university co-educators, attains a considerable independence of decision and action. The public health nurse, working within the frame work of medical and agency policy, operates with a large degree of independence in her decisions and her plans for family care and teaching. In contrast, the nurse administrator, working with hospital administrators, medical staff, and, in teaching hospitals, with the medical interns and residents, finds herself all too often in a semi-competitive situation with doctors unwilling to relinquish responsibility, even for activities for which they cannot find the time or are themselves less well adapted to do. There is, too, the hospital administrator who, having employed the nurse director to run the Nursing Department, is unready for his own reasons to relinquish the authority commensurate with the delegated responsibility.

Women who went into Nursing in the late 19th and early 20th centuries were products of one world. Women who seek education for nursing today belong to yet another. And the two generations of women have found the use of their capacities and their satisfactions in different ways. Given background of knowledge and experience, today their interests turn more toward independence of thought and action at all levels of experience, from the staff nurse to the administrator. This then presents a problem at all levels of responsibility. The well prepared collegiate nurse, the able graduate of any nursing program, more and more tends to seek employment where medical and administrative relationships provide opportunity for decision and for exercise of individual initiative and skill. The hospital services will do well to consider the problems arising from this situation. Will the hospital administrator give such opportunity to the nurse director that she may work to help her staff make their maximum contribution? Will the doctor see the nurse as having preparation for responsibilities in patient care, different from his, but complementary to the medical program?

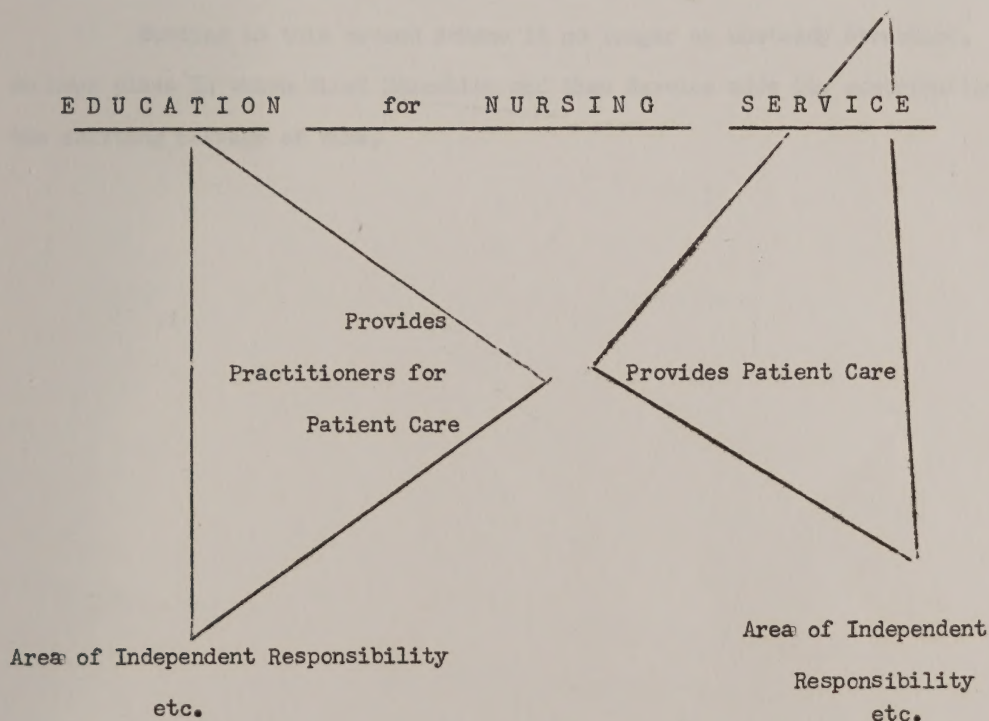
Unless this situation pertains, the full values of progressive care units, of intensive care service, or facilities for critical care will never attain maximum value to patient or medical service or hospital. And nurses will go elsewhere. Experiments have shown that nurses can conduct with great success their own patient clinics, thereby releasing doctors' time, and providing a patient service even more successful. Other experiments indicate that a nurse working as a specialist can integrate all facets of nursing care, serving as the hospital staff nurse and the private nurse, and pre and post hospitalization as the public health nurse. Such a nurse works with hospital administration, medical staff, nursing staff, and as necessary outside the hospital with other community facilities. She brings a wholeness to patient care. The very success of such experiments demonstrates what can be achieved with the right preparation of the nurse when she has commensurate authority to plan, and make decisions. These experiments also illustrate clearly the trend nursing could take and the effect of such nursing on the need for greater numbers of nurses for patient care. The conflict will come even more between quality of care, not only to be desired because it is comfortable and good, and the quantity of care necessary to save life.

The nurse of the past who chafed at times at orders and restrictions nonetheless accepted as her responsibility the administrative plan which provided care as patients' needs required. Patients were full time residents in the hospital. Nurse coverage was expected twenty-four hours, seven days a week, three hundred and sixty-five days a year. Concomitant with the new freedom of this era, with acquisition of more knowledge, with a growing concern for status, with improved financial resources, is the desire for self-determination in personal life as in professional practice. Like the doctor, the nurse looks to free week-ends and hopes not to be involved in the demands for care in the evening or in the night.

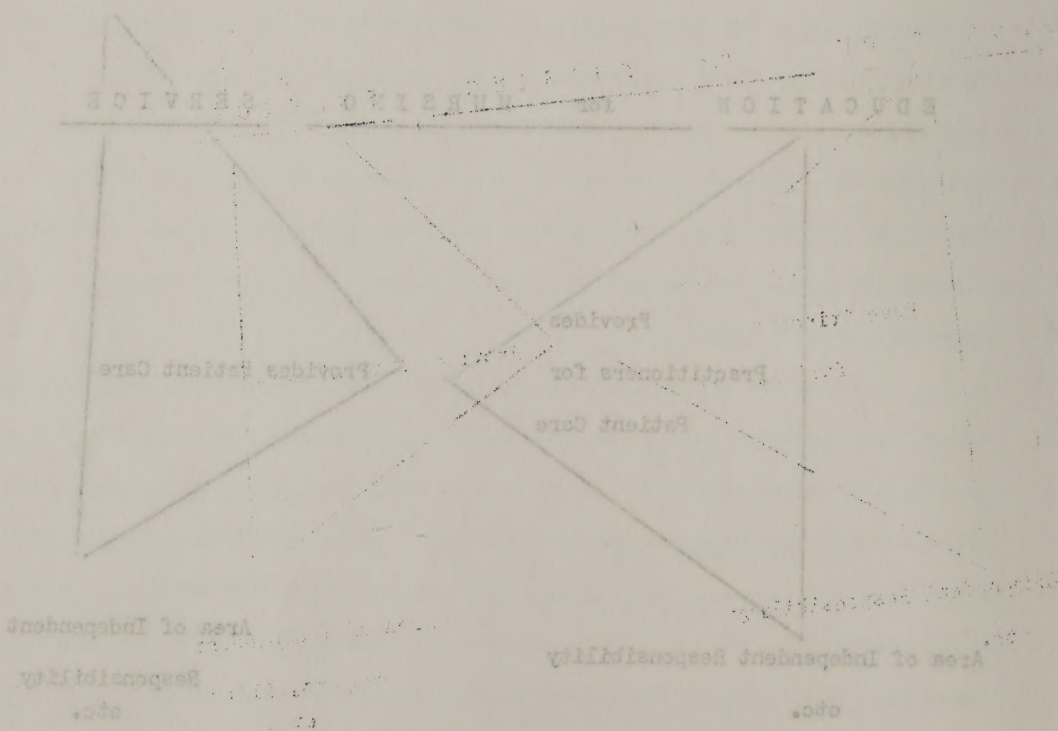
The market today and tomorrow will belong to the buyer. With no competition for jobs, eligible to work where she will, the nurse moves freely, sometimes to be with family, again to increase her income, frequently to use her skills more effectively,

and more often than we know to escape what is unpleasing or difficult. The future holds no hope of improvement to decrease the instability of the Nursing Service save through a combined attack by hospital administrations, doctors, nurse educators, and nursing service administrators on the present ills in education and work situation and relationships in the hospitals.

Now again if I had a blackboard I would draw what I hope may be a better picture for nursing in the future.



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The difference in the two schemes lies in the coming together of Education and Service toward the same goal. Service approaching directly; Education making its approach through the contribution of its products. Free communications bring mutual benefit. There will be free flow of knowledge, of stimulus, and I hope of people themselves contributing to the advancement of both Service and Education.

And, where does the medical man or the hospital administrator fit in this scheme? Their relationships are woven into the entire fabric of patient care. They, working with the nurse to support as she in turn supports them. They, seeing the nurse as both a contributor in her own right and an integrator of services, bringing organization to the total plan for patient care.

Nursing in this second scheme is no longer an unsteady structure. Now like an hour glass in which first Education and then Service adds its contribution with the shifting passage of time.

January 30, 1967

Mr. James E. Hague
Editor and Assistant Director
American Hospital Association
850 North Lake Shore Drive
Chicago, Illinois 60611

Dear Mr. Hague:

I am enclosing the article and trust it is satisfactory. It was impossible for me to fill in the volume numbers for some of the articles in HOSPITAL MANAGEMENT and HOSPITAL PROGRESS, since I do not have access to these.

Sincerely yours,

Encs.
RS:BF

Ruth Sleeper, R.N.

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NURSING SERVICE

by

Ruth Sleeper, R.N.

Too much has been said for too long about the shortage of nurses. It is time attention was turned toward the study of those factors which increase the effectiveness of available personnel and facilities in hospitals. In any study or subsequent implementation of findings the degree of success attained will be dependent on the involvement of all interests concerned; the time allowed for interpretation of the findings to individuals who will be affected by the change; and the preplanning done to prepare personnel to give up the old patterns to use the new. Modified or new roles for nursing personnel, different patterns of hospital or nursing service organization with especial attention to departmental relationships, and facilities designed to meet changing work patterns should all result from such studies. Inter-hospital and intra-departmental communications can no longer be left to chance. Nor can any one individual serve as the link or any single meeting serve to meet the whole need. Problems of communications may be studied but key personnel will need preparation and assistance in institutions where the complex and rapidly moving programs in each department involve the individual so intensely in his own activities as to screen from his view the interrelationships necessary to meet the common goal of patient care.

New Philosophies Are Applied In Reorganization

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supervisory personnel performance." (1) "The hospital operates most effectively when the nursing department assumes full management of the facilities in which in-patients are bedded and also continuous control over the care the patients receive." (2) This author would delegate to the nursing department responsibility for some activities now carried in some hospitals by other categories of personnel. He would reduce the numbers of these other personnel contacting the patient for such purposes as intravenous infusion and inhalation therapy, thereby continuing these demands upon the already heavily burdened leadership group in nursing. "The direction which medicine and hospital service has taken has placed great burdens on nursing. The nurse's education prepares her for patient care, but practice has put her into an overwhelming situation." (3)

"The place of the nursing department in the current reorganization of hospitals still is not clear to most hospital administrators or to many nurse directors or other department heads." (4) One author deals with the application of management theory to nursing showing the effect of social revolution on the internal structure and operation of the hospital. In studying the organization of a nursing department the need for a more effective role of the supervisor becomes apparent. New responsibilities with commensurate authority are planned. Some suggested changes in roles are based on the belief that no one director of nursing can carry all the functions necessary in the administration of a large nursing service in a large hospital. One institution finds its appropriate solution in the appointment of five nurses each with her own division of responsibility. Each reports to a nurse administrator for over-all coordination of nursing services. In another hospital a series of personnel activity studies resulted in development of an experimental nurses' station and the assignment

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Two Roles Are Tested

"In considering the various functions carried out within a nursing unit the major divisions are obvious. The nurse is responsible for nursing care while the physician's responsibility is for medical care and treatment. Now with the area administrator we add still another division to the patient-care team with responsibility here being for administration, management, and ancillary functions." (10) Such workers in other situations called unit managers or ward managers assume a variety of responsibilities to free head nurses and other nursing personnel from activities not directly related to patient care. Hospitals vary in placing the administrative responsibility for the unit manager program. Some are responsible to the hospital administration, some to the nursing service. As institutions differ in breadth of preplanning, in preparation of staff for role changes when the unit manager plan is introduced and in communications between administration and nursing at all levels, so vary the degree of acceptance and the progress of the plan.

A second role still in evolution is found in the nurse who has acquired special preparation in one area of nursing care. To such a nurse is usually delegated responsibility for planning patient care and for teaching and guiding those who give the care. She works with doctors and others involved in the care. She interprets to families. She brings depth into planning, continuity into service, and quality into total care. Job descriptions are still in the making.

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Definitions vary widely for the nurse specialist according to the clinical service in which she is involved, the organization of the nursing service in which she works, the freedom and authority she is given, and the initiative and skills she possesses.

One author discussing the clinical nurse specialist sees need to change the organization of the nursing department radically. He suggests a less stratified hierarchical structure and one in which many less distracting activities are allocated to the nursing department. In his opinion the nursing staff ultimately may become organized in a pattern much like the one used by medicine. "Intuitively nurses seem to want to bring about a resurgence of clinical practice." (22) Too long the only advancement possible for a staff nurse has been through promotion to a managerial position. The development of the clinical nursing specialist now offers, to those who will prepare for it, advancement with continuing opportunity to give patient care.

New Methods Of Assignment And Time Planning Are Studied

At a time when personnel are too few assignment becomes a major problem for both the administrator who tries to fill all necessary posts with proper skill levels and for the nurse whose concern over hours may be the basic cause of lowering morale. Once the staff needs are established cyclical scheduling has been found successful. It saves time. It gives a more even and acceptable distribution of desired time off. It has even appeared to attract nurses to work where time off can be known in advance and depended upon. That cyclical scheduling once established can be carried on in a central office by a non-nurse means saving of head nurses' and supervisors' time in significant amounts.

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Facilities Are Planned To Save Time And Energy

Rising hospital costs and increasing occupancy at a time of insufficient supply of nursing personnel influence the size of new patient care units. "Although size is important, layout of unit, traffic, delivery of supplies, trash removal, etc. are equally important and really have more to do with 'joy of working' than size." (35) If the major function of the staff nurse in patient care is supervision of others giving that care, the larger unit if properly designed may be practical from the nurses' view point too. Except for facilities for the post operative patients, for the critically ill and patients in special units such as units for coronary patients, architects and hospital administrators appear to prefer single rooms rather than multiple care units. Whatever the type of room provided, the hospital must decide what it will expect from the nursing staff. Should the head nurse know the patients and families as she could in the smaller unit of 30 beds, or leave the guidance of patient care largely to staff nurses, team leaders or others in a unit of 60 or more beds? Efforts to include safety features for patients and time and work savers for nursing personnel are evident in planning new buildings or remodeling old: intercom systems, monitoring systems, special floor telephone extensions, central location of service and treatment rooms, avoidance of long corridors, grouping of rooms to facilitate supervision.

Planning for progressive patient care continues both to improve utilization of beds and to secure economy in staffing. One author, after six years trial, writes "P.P.C. has proved so successful that the original three-stage program now includes a fourth phase of continuing care, and proposed building plans fully incorporate the concept." (37) In contrast a second author in his third article dealing with minimum care concludes: ". . . many people looked

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at progressive patient care as a means of reducing costs, whereas an overriding consideration may be the effect on quality of care." (4) Several factors persist throughout discussions of progressive care: the facilities must be remodeled to suit the needs of patients and staff, the staff must be commensurate with the patient care expectations in numbers and skill levels, education must be provided to prepare for acceptance of the concept implicit in such units. Education is needed by patients, families, nursing personnel, medical staff and all others who share in the care of patients in the units.

Evaluation Of Present And Proposed Plans Are Necessary

Too little has been written about evaluation of the services rendered to patients by nurses. Attempts have been made to introduce a nursing service audit which concentrates upon the accuracy and completeness of nursing records as indices of adequacy of care. One author describes a "Scientific Approach to Quality Control" in which "... quality control is defined - as the method of determining how close observations of care meet prior expectations of care." (41) In this situation three indices are included in the nursing audit: records, medication errors and food waste.

Sights Are Set For The Future

Certain facets of patient care not emphasized in the literature in 1966 may be stimulated by the natural course of events in the coming year. To assist with the best possible utilization of extended care facilities nurses need to do more planning with administration and medicine. Nursing is a primary ingredient in continuing care. Without adequate study and planning by nursing for continuity of nursing care efforts by other groups will prove ineffectual and incomplete.

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as indices of adequacy of care. One author described a "Scientific Approach

audit which concentrates upon the accuracy and completeness of nursing records

patients by nurses. Attempts have been made to introduce a nursing service

Too little has been written about evaluation of the services rendered to

Evaluation Of Present And Proposed Plans Are Necessary

medical staff and all others who share in the care of patients in the units.

in such units. Education is needed by patients, families, nursing personnel,

education must be provided to prepare for acceptance of the concept implicit

commensurate with the patient care expectations in numbers and skill levels,

must be remodelled to suit the needs of patients and staff, the staff must be

factors persist throughout discussions of progressive care: the facilities

riding consideration may be the effect on quality of care." (11) Several

at progressive patient care as a means of reducing costs, whereas an over-

In consideration of staff, in planning for the development of new nursing roles, more attention must be paid to the abilities of the three groups of registered nurses now coming to hospitals to work. Failure to plan for these variations will result in greater dissatisfaction both in the nurse herself and in the nursing service administration. Hospital administration, nursing, and medicine need more information from the colleges about the new graduate's abilities on graduation and her readiness to adjust to nursing service organization and pressures. College faculty need to know the hospital nursing situation more intimately. New and more appropriate in-service education plans are needed for each group or if necessary for each individual. Confusion resulting from three different modes of preparation is more a problem of communications than of differences in programs. Differences can be put to positive use. Future in-service education programs in hospitals must be developed as carefully as curriculums are planned for schools of nursing. Teachers must be equally well prepared.

More nursing research is urgently needed for improvement of patient care. All nurses are prepared for some level of patient care, fewer are ready to direct others wisely; study is needed to help in this area. Few nurses understand the hospital or the patient care unit as a social system; further investigation and education would decrease problems here. Many misconceptions grow because nurses, doctors, and administrators fail to discuss broad issues in hospital operations or professional organizations and their programs; serious attention is needed in this area if the welfare of the patient is to be more than a phantom goal for the years to come.

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American Hospital Association

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October 20, 1966

Miss Ruth Sleeper
Director of Nursing Service
Massachusetts General Hospital
Boston, Massachusetts

OCT 24 1966

Dear Miss Sleeper

You probably are familiar with the Annual Administrative Reviews issues of HOSPITALS, J.A.H.A. Each year for the past decade this special issue of the Journal has offered what we think is a useful service to those interested in keeping abreast of progress in the various specialties of health care administration. The 1967 issue, to appear April 1, will carry summaries of literature published in 21 subject areas.

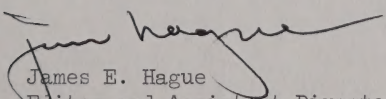
We understand that your work schedule is not as demanding as it has been, leading us to hope that you might be in a position to accept this invitation to prepare an evaluation and summary of the literature covering the field of nursing service. The enclosed fact sheet outlines the procedures and format for writing the review.

Also enclosed is a tear sheet of last year's review of literature in this subject area. Scanning this article and its list of references will give you some idea of the scope of the literature pertinent to this subject heading in the context of the issue.

To assist in the collection of literature on which the article is to be based, we have the following plan: For material published in the first six months of the year, copies of pertinent material taken from the six major hospital field journals will be sent to the reviewer; for the second six months, subscriptions to these journals will be placed in the name of the reviewer.

In order for us to meet our printing deadline, we will need to receive manuscripts for the issue no later than February 1, 1967. We hope that you can accept our invitation to undertake this project. We assure you that we will be available to help in any way possible.

Sincerely yours



James E. Hague
Editor and Assistant Director

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HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

FACT SHEET - ADMINISTRATIVE REVIEWS

PURPOSE: The Administrative Reviews provide the hospital administrator and his executive staff with meaningful summaries of selected developments and activities in the major sectors of the hospital field. These reviews of literature published during the previous calendar year are based on and correlated with selected bibliographies drawn from literature of the hospital and allied health fields.

A reviewer need not cite or discuss all published articles pertaining to his review assignment, but he should rather treat those that, in his judgement, report significant developments, indicate major trends, or are otherwise pertinent.

ORGANIZATION: Each review consists of three sections--general background information, a review and commentary on the year's literature, a summary, and a reference list.

The Background, usually two or three paragraphs, is a statement of basic facts and principles that serves as a background for the subsequent discussion.

The Year in Review covers major developments, trends, issues, and other activities in the area under discussion. These generally are reflected in the literature provided, although the reviewer is free to cite other material he considers significant. Articles, books, and other source material should be footnoted at appropriate points in the review. The author is encouraged to comment freely on the content and quality of the literature.

The Summary and Outlook, a paragraph or two, contains the author's conclusions about the area studied and the literature he has reviewed, together with commentary on future prospects.

The references should be listed in the same order in which they are cited in the review. In most instances, 30 to 40 references will adequately cover the subject matter of the review. Cited references have value for the reader only if their content is discussed at least briefly by the author. References should be given in the following form: Author (surname and initials); title of article; name of publication or book; volume and initial page number (e.g., 33:44); and month and year (e.g., Sept. 16, 1966). For obvious reasons, it is extremely important that citations be accurate.

LENGTH: The text of the discussion should not exceed 2000 words, or from six to seven double-spaced, typewritten pages. Manuscripts, including references, should be typewritten and double-spaced throughout.

COPIES: Two copies of the manuscript are needed--the original and one carbon.

